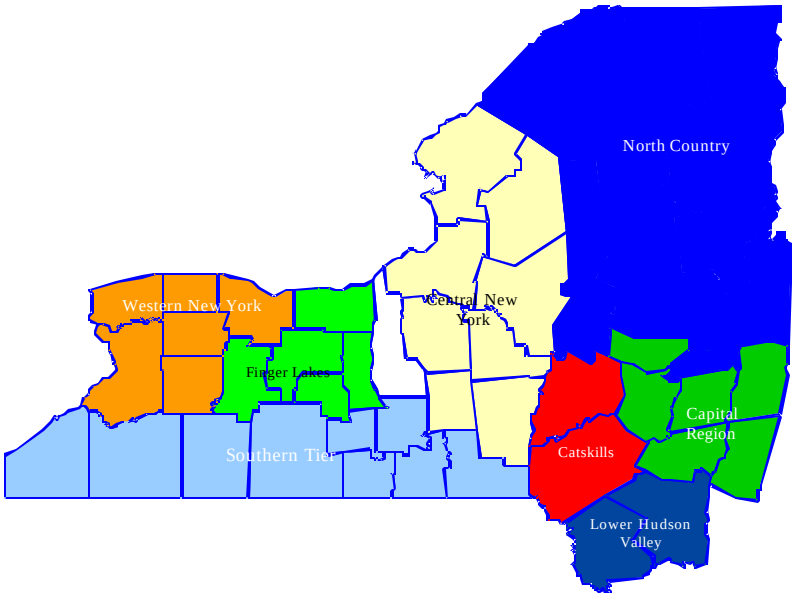
KENNETH W. KIZER QUALITY ACHIEVEMENT AWARD APPLICATION



VA Healthcare Network Upstate New York – Network 2
December 7, 2001

2001 Kenneth W. Kizer Quality Award Application
VA Healthcare Network Upstate New York-Network 2

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P.1a Organizational Environment:

Between 1996 and 2001, Network 2 successfully transformed its health delivery system, providing services to significantly greater numbers of veterans while achieving excellence in health care quality and customer satisfaction. This transformation was achieved through a systematic process by which well-defined performance targets were established in those areas crucial to organizational success **(**Critical Success Factors- **Fig 0.1)**.

CRITICAL SUCCESS FACTORS

- **Provide Excellence in Quality**
- **Achieve Outstanding Veteran Satisfaction**
- **Provide the Best Health Care Value**
- **Treat Greater Numbers of Veterans**

Fig. 0.1

Also significant was the establishment of an innovative Care Line structure that permitted rapid systems transformation, through the development of network-wide goals and operational strategies. The essence of Network 2's successful transformation was the development and ongoing monitoring of key performance indicators that would be readily communicated through the entire Upstate New York Network. These indicators were identified as critical determinants of organizational success **(Fig 0.2)**:

Significant investments in information and data technology were introduced at the outset, providing senior leaders and staff at all levels of the organization with the necessary tools to assess organizational progress and achieve measurable improvements in performance. The intent is to establish a superior health delivery system by achieving the highest levels of quality and customer service, measurable throughout both VA and the private sector. We aim to achieve or surpass the 90th percentile nationally for standardized measures of patient satisfaction and quality. Organizational Principles are presented in **Fig 0.3**.

ORGANIZATIONAL PRINCIPLES

- **SET PERFORMANCE EXPECTATIONS THAT FAR SURPASS ALL CURRENT HEALTH SYSTEMS**
- **BENCHMARK WITH THE BEST HEALTH CARE & NON-HEALTH CARE ORGANIZATIONS**
- **EMPOWER ALL STAFF THROUGH SELF-DIRECTED ACTIONS**
- **ENCOURAGE & REWARD CREATIVITY AND TEAMWORK**

Fig. 0.3

Organizational Performance Environment: The reengineering of Network 2's health delivery system was based upon the wide deployment of these transformation principles and the development of shared accountability for achievement of targeted goals. Between 1996 and 2001, Network 2 achieved or approached VA best practice in each of the four areas deemed crucial to organizational success (Critical Success Factors), while approaching performance of the best health care systems in the United States. In support of the first factor, excellence in quality, Network 2 achieved the exceptional level in adherence to recommended clinical practice guidelines (CPGs), achieving VA best practice, for such quality metrics

DETERMINANTS OF ORGANIZATIONAL SUCCESS

Critical Success Factors	Indicators of Success	Desired Outcomes
Provide Excellence in Quality	Achieve quality and prevention scores at the highest level of the health care industry using NCQA and Healthy People 2010 targets	♦ Provide Excellent Preventive Health ♦ Improve Health Status of Veterans ♦ Improve Overall Community Health
Achieve Outstanding Veteran Satisfaction	Achieve Excellent Satisfaction Scores and excellent Clinic waiting times	♦ Retain a Greater % of Patients ♦ Attract New Patients ♦ Improve Timeliness of Care
Provide the Best Health Care Value	Generate costs that are competitive within VA and Private Sector including pharmacy	♦ Redirect Savings To Develop New Programs ♦ Expand Treatment Capacity
Treat Greater Numbers of Veterans	Generate sustained rates of patient growth which surpass VA and private sector HMO norms	♦ Generate Maximum Revenue ♦ Provide Benefits to Greater Numbers of Veterans

Fig. 0.2

as colorectal cancer screening, Mental Health follow-Up, diabetes foot exam and Major Depression Screening. In accordance with the second factor (veteran satisfaction), Network 2 achieved VA's highest satisfaction scores for access to care, clinic waiting times, specialty care and Home-based Primary Care (HBPC). Overall outpatient satisfaction equaled 70.1%, the 2nd best among 22 VA network, comparing favorably against the highest rated HMOs in New York State. With regard to the third factor (Value), cost per patient was reduced by 41.5% since 1996, adjusting for inflation, the 2nd greatest reduction in unit cost among all 22 VA networks, resulting in unit costs 23% below Medicare cost per enrollee and 15% below the average health plan cost for 600 companies Concerning the fourth success factor (Patient Growth) an 8.8% annual increase in market share since 1996 surpassed all categories of non-profit, for profit or government health systems **(Fig. 7.2M),** an achievement especially significant for an area experiencing disproportionate veteran population losses. These achievements were realized despite VA headquarters' projections of sharp patient reductions for Network 2, in favor of sun-belt networks. This transformation in patient growth and cost effectiveness resulted from expansion of outpatient and community based clinics, improved use of alternate treatment settings and through improved delivery practices, including reduction of unnecessary hospitalization. **(Fig 7.2E)**

Senior leaders defined success as achieving the highest performance level between VA and private sector organizations for all 4 of its critical success factors (quality, satisfaction, value and growth). These performance expectations continue to be revised upward, targeting the 90th percentile nationally for all measures of organizational success.

P.1a(1) Organization Description: The VA Healthcare Network Upstate is an integrated health care delivery system, serving veterans in 47 counties in New York State as well as two in Northern Pennsylvania. Network 2 provides a full array of inpatient, ambulatory and long term care services, including a full range of medical, surgical and mental health specialty services. This health care network provides inpatient facilities at six locations including Albany, Batavia, Bath, Buffalo, Syracuse, and Canandaigua, while operating a network of 29 community-based clinics throughout the region.

The VA Healthcare Network Upstate New York maintains a Care Line Matrix structure through which a full range of health care services are provided to veteran patients **(Fig 0.4)**.

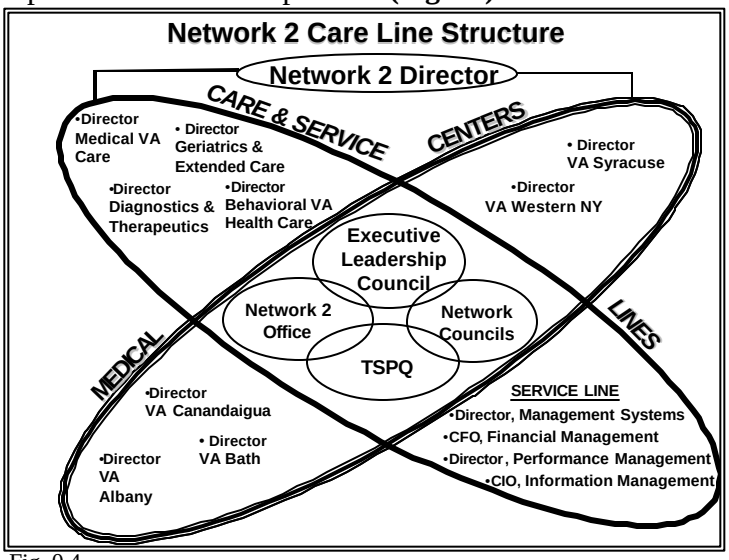


Fig. 0.4

In contrast to traditional hospital and network delivery systems, line and budgetary authority are assigned to Care Lines, arranged horizontally across a network of Medical Centers, clinics and nursing home care units. Initiated in 1997, this reorganization was designed to create an effective integrated delivery system, which promotes one standard of care across the Network **(Fig 0.4)**. The implementation of Network-wide care lines has redirected attention to network-wide rather than facility-based needs, and has promoted a significant transformation in cost effectiveness, patient growth, customer satisfaction and quality for Upstate New York's veterans.

P.1a(2) Mission, Vision, Values:

MISSION:

"To Care for our Veterans With Compassion and Excellence."

VISION:

To be the Health care Provider of Choice, Achieving the Highest Quality in Health Care Delivery, Education and Research

VALUES:

Trust, Respect, Commitment, Compassion and Excellence.

The percentage of the Network 2's veteran population treated has increased from 12.6% in 1997 to 20.5% in 2001, achieving the 3rd highest market penetration behind Network 8 (Bay Pines) and Network 18 (Phoenix) **(Fig 7.1A)**. Network 2 has a principal market segment composed largely of male veterans with limited income, although a growing number of women veterans continue to receive care. 48% of Network 2 enrollees are over age 65; the average user income is $16,481 with 75% earning less than $20,000 annually and 61% of users carrying no health insurance.

P.1a(3) Staff Profile: Network 2 currently employs over 5200 staff, with 55% involved in direct patient care activities, 28% administration, and 16% involved in facilities management.

The staff is supplemented with over 4,000 volunteers who have contributed over 545,000 man-hours of service in the past year. Network 2 has active labor partnerships with the Service Employees International Union, American Federation of Government Employees, and the New York State Nurses Association. The number of staff by category of employment is provided in **(Fig 0.5)**.

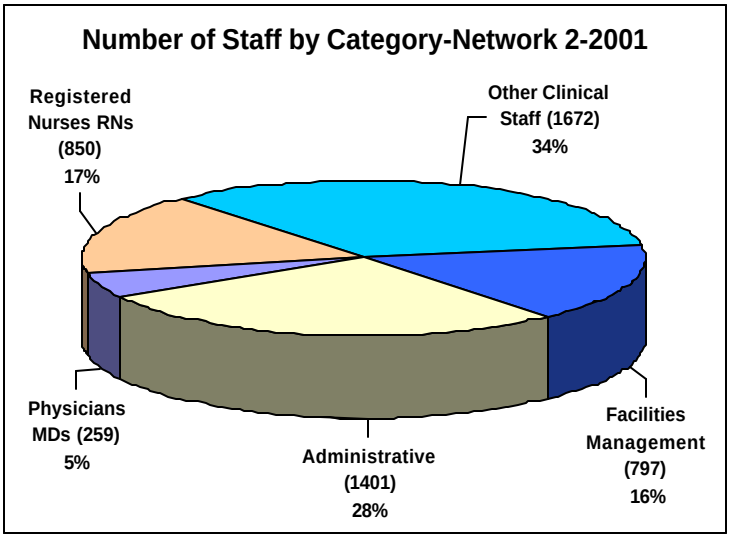


Fig. 0.5

P.1a(4) Technologies, Equipment and Facilities: Network 2 maintains three acute/urgent care facilities (Buffalo, Syracuse, and Albany) that provide a full range of acute medical, surgical and mental health services. The average age of the Network 2 Medical Centers is 46.2 years. This creates the need for ongoing costly maintenance and needed renovations to accommodate the delivery of preferred outpatient services. Network 2 has invested in a telecommunications infrastructure capable of supporting technologically advanced applications including full data base integration, a computerized patient medical record system, telemedicine and extensive video teleconferencing.

P.1a(5) Legal and Regulatory Environment Network 2 has led the Department of Veterans Affairs in seeking voluntary accreditation, applying the highest standards of quality, well beyond traditional VA and Joint Commission on Accreditation of Healthcare Organizations requirements. Network 2 was the first Network to seek accreditation from the National Commission on Quality Assurance, the primary accrediting body of health maintenance organizations, receiving a two-year accreditation in 1999 with a rating of commendable. Only Networks 2 and 15 (Kansas City) have received accreditation from the National Commission on Quality Assurance. Network 2 has maintained its accreditation by CARF – The Rehabilitation Accreditation Commission. In addition, fourteen separate Behavioral Health programs have attained full three-year accreditations, also receiving recognition from CARF for sixteen examples of exemplary conformance to standards. In addition, the Network 2 Healthcare for Homeless Veterans Program was the first program nationally, to seek a Network-wide accreditation from CARF, also receiving a full three-year accreditation with no recommendations. CARF noted in the accreditation letter that only 3% of the organizations surveyed result in no recommendations. Additional accreditations include Occupational Safety & Health Administration, Nuclear Regulatory Commission, College of American Pathologists, and the Joint Commission on Accreditation of Healthcare Organizations. The Joint Commission on Accreditation of Healthcare Organizations surveyed all sites, in Network 2, in 2000 under the Hospital, Behavioral Health, Long Term Care, and Home Care Standards. All survey results were greater than or equal to the National Healthcare average. **(Fig. 7.4J-L).** Network 2 has continued to apply Malcolm Baldrige criteria in order to improve its organizational processes and results, using the results of the feedback reports from Kizer, Carey, and Baldrige applications. In 2001, Network 2 won

the Robert W. Carey Award, VA's most prestigious award for organizational performance.

The VA Healthcare Network Upstate New York is one of twenty-two Veterans Integrated Service Networks **(VISNs)** nationwide that constitute the Veterans Health Administration (VHA), the nation's largest integrated health care system **(Fig. 0.6)** With a budget of more than $500 million, Network 2 provides health care to approximately 125,000 veterans through 5 medical centers, 29 community based clinics and 6 nursing home care units. In addition to its medical care mission, the veterans healthcare system is the nation's largest provider of graduate medical education and one of the nation's largest medical research organizations. VA also provides backup to the Department of Defense and the National Disaster Medical System.

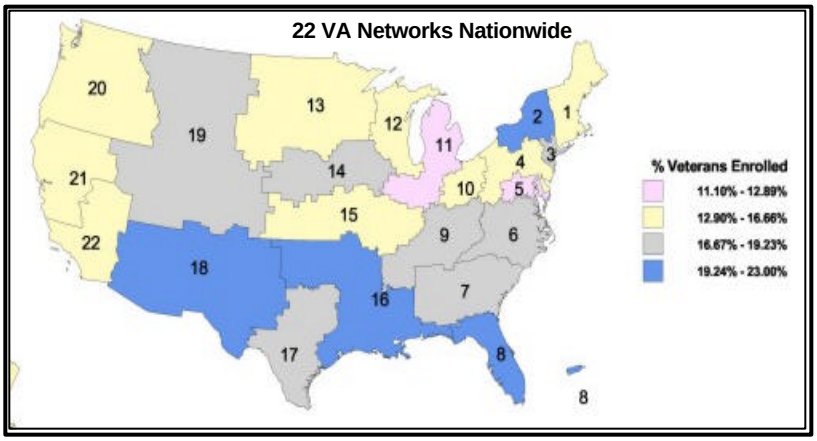


Fig. 0.6

Network 2 has introduced plans to assure that full integration of health care services is provided to veterans. This is accomplished through the availability of primary care programs at all sites including Community Based Outpatient Clinics (CBOCs), greater involvement of geriatrics and mental health staff on Primary Care Teams, and expanded partnership with community organizations. Network 2 maintains staffed programs in the inpatient, outpatient, and home care settings while also maintaining nursing home care unit beds, through either VA-operated or contract nursing homes within the community. Network 2 strives to provide a consistent level of care to the veteran population through greater uniformity and standardization of services, greater application of clinical practice guidelines and disease management protocols and through the establishment of standards for all clinical disciplines.

P.1b Organizational Relationships

P.1b(1) Patient/Customer and Health Care Market Requirements: Network 2's customers are veteran patients, who require a full range of medical, surgical, behavioral health and long-term care services. These services require easy accessibility throughout Upstate New York **(Fig 3.3)**, are provided in a timely and courteous manner, and are offered in a manner which elicits the highest levels of patient satisfaction. Network 2 will be successful to the extent that patient growth and retention are optimal, by striving for world-class customer service and excellence in health care quality. Services are provided for a growing number of women veterans, including vital screening programs **(Fig 7.1F&G)**.

Patient/Customer market Requirements are determined by incorporating information from diverse sources including customer satisfaction results, veteran service organizations, patient complaint data and Quick Card responses. The Network 2 Customer Service Council continually solicits information from patient groups in order to improve access to care, timeliness and all facets of patient satisfaction. Through listening and learning techniques, a wide range of new products and services are introduced that further improve customer service. Information has also been obtained through collaboration with other VA networks in order to share best practices and continually improve performance. Network 2 has hosted best practice workshops for visiting staff from other networks and has submitted many initiatives for inclusion in a Customer Service Best Practice Guidebook. Performance targets designed to exceed customer expectations, have been established through 2006. **(Fig. 2.9)**

P.1b(2) Supplier and Partnering Relationships: Network 2 maintains effective relationships with vendors and community organizations to assure timely and effective delivery of services as well as optimum use of available resources. Effective negotiations with vendors and suppliers have produced considerable cost savings through contract standardization **(Fig 7.4H)**. Effective sharing agreements with community organizations have produced additional revenue, by making effective use of available resources. Network 2 continues to work with vendors in arranging group-

purchasing agreements, resulting in significant cost savings. **(Fig. 7.4I)** Timely provision of mail-out prescription services has resulted through effective contractual arrangements, with improved turnaround times.

P.2 Organizational Challenges

P.2a(1) Competitive Environment: Network 2 operates in an environment of declining veteran population, in which VA budget appropriations are apportioned in accordance with the numbers of patients receiving care. VA Healthcare Network Upstate New York competes with other networks for a percentage of the VA budget, especially networks in sun-belt areas in which the veteran population is increasing. Network 2 also competes with local health care providers and hospitals for veteran patients and must strive to deliver care that adheres to the highest standards of timeliness, quality and patient satisfaction.

P.2a(2) Principle Factors for Success: Success is based on the extent to which veteran population losses are offset by successful patient enrollment efforts and improved health delivery processes, in order to generate greater funding Network 2 must also provide patient care amenities and facilities as well as customer service which is competitive or superior to community facilities.

P.2b Strategic Challenges: Challenges include treating greater numbers of veterans despite a declining veteran population, in order to generate greater funding. We must continually improve patient satisfaction and quality scores in order attract and retain our patients, which will in turn improve future budget allocations. In addition we must retain and attract high quality staff by promoting a work environment which offers employees professional fulfillment and growth potential. We must continue to improve staff productivity, improve health delivery practices, including reduced unit costs and improved use of alternate treatment settings, while decreasing unnecessary hospitalization. Improved productivity and corresponding unit cost reductions will produce improved funding in accordance with the Veterans Equitable Resource Allocation (VERA) Model, the principal determinant of Network funding.

P.2c Performance Improvement System:
We seek to improve performance by setting performance standards at the highest level of the health care industry, including our staff in improvement processes, and using advanced data systems to monitor and improve performance. Network 2 is embarking on significant improvements in health delivery through advancement of disease management programs and greater use and application of clinical practice guidelines. Improvements in health delivery will result through standardization of practices, while encompassing and applying a wider body of health care knowledge now available for providers. Network 2 is committed to improving the health status of the veteran population through greater Mental Health and Geriatric support to Primary Care Teams, computerized imaging and through improved outreach programs for high risk veteran groups. Partnerships will be forged with community organizations, in order to optimize the use of health care resources, while assuring that state of the art services are available to veteran patients.

Network 2 is also committed to improving customer service including reductions in waiting times, standardization of care through disease management programs and clinical guidelines. Access to care is being improved through Network 2's Web Page, recipient of the 2001 VHA Best of the Web and through a 24-hour telephone Virtual Help Desk. Network 2 has undergone an integration of its patient database among all facilities and community based clinics to improve continuity of care and timely access to patient information from any location. The following represents our approach to providing superior health care delivery over the next five years **(Fig. 0.7)**:

Fig. 0.7

1.0 LEADERSHIP

1.1 Organizational Leadership

1.1(a) Senior Leadership Direction:

The VA Healthcare Network Upstate New York is an integrated health care system dedicated to delivering excellent health care services to the veterans of Upstate New York. Our senior leaders are committed to the following principles **(Fig.1.1).**

SENIOR LEADERSHIP PRINCIPLES

- **SET PERFORMANCE EXPECTATIONS THAT SURPASS CURRENT HEALTH SYSTEMS**
- **EMPOWER ALL STAFF THROUGH SELF-DIRECTED ACTIONS**
- **DEVELOP SHARED ACCOUNTABILITY TO TRANSFORM THE ORGANIZATION**
- **RECOGNIZE AND REWARD ALL STAFF**

Fig 1.1

Network 2 was the first VA Network to remove the traditional hierarchy associated with health care organizations and replace it with a Network – wide Care Line structure. Designed in 1997, this matrix design assigns programmatic responsibility to "Care Lines" arranged horizontally across a network of medical centers and outpatient clinics. Benefits include a high degree of collaboration and shared accountability as well as the emergence of new leaders previously hidden by traditional hierarchies. This structure, along with a culture which promotes self-directed staff actions, has produced performance at the highest level of both VA and private sector organizations, and has resulted in the following national awards. **(Fig. 1.2).**

NETWORK 2 NATIONAL AWARDS

- **2001 Robert W. Carey Award**
- **2001 Undersecretary's Award for Innovation-On Demand System**
- **2001 Best of the Web Award**
- **2001 Labor-Management Cooperation Award**
- **2000 OPM Pillar Award for Goal Sharing**

Fig. 1.2

In 2001, Network 2's Baldrige application scored in band 4 (451-550 points), reaching the Consensus Phase, with only 16% of all national applications scoring above this level.

The Network Director, Frederick L. Malphurs, is responsible for all care provided throughout the Network and is accountable to the Undersecretary for Health, Thomas Garthwaite M.D. Senior leadership within Network 2 consists of Network Care Line Directors, Medical Center Directors and Network staff who work in close collaboration to set the strategic direction for the organization, actively design the organizational structure and processes, and assure superior performance. The governing body, the Executive Leadership Council (ELC), is unique in that there is stakeholder representation by union members and veterans' advocacy groups. **(Fig 1.4)**.

Also unique is our Clinical Consultant program, a collective of key physician leaders from all sites in all specialties that set clinical policy and share in governance. The Management Advisory Council (MAC), composed of key veterans' advocates from all of New York State in both VISN 2 and VISN 3, is consulted twice yearly on policy development. A sub-group, the NY State Veterans Service Council works continuously to smooth the interface between the two VISNs for seamless, shared service to veterans, irrespective of county.

1.1a(1) Organizational, Values & Expectations:

Our leaders are personally involved in the formulation of the Mission, Vision and Values of Network 2. We spend several months in discussion, refinement, and seek input and consensus from all levels of management. Once approved by the ELC, Care Line leaders, Medical Center Directors and other senior leaders personally discuss them with line staff in open meetings, post them in highly visible places within each building and community-based clinic, and distribute them with ID badges. *Goal sharing (Fig 2.6) and interactive planning (Fig. 2.2) are two processes which require direct championing by senior leaders as well as active staff participation at all levels*. Monthly ELC meetings are structured around each of the 7 Baldridge sections. Our Critical Success Factors are: **(Fig 1.3).**

CRITICAL SUCCESS FACTORS

- **Provide Excellence in Quality**
- **Achieve Outstanding Veteran Satisfaction**
- **Provide the Best Health Care Value**
- **Treat Greater Numbers of Veterans**

Fig. 1.3

Communication tools include web pages, e-mails posters and booklets and are used to convey the message of mission, vision, values and

ESTABLISHING & DEPLOYING VALUES & EXPECTATIONS

	ESTABLISH	*COMMUNICATE*	*DEPLOY*
Organizational Values	Development of Mission, Vision & Value Statements and Critical Success Factors	Mission, Vision Value Posters; Town & Staff Meetings; Meeting with the Director(s); ID Badges; Executive Leadership Council (ELC); Local Leadership Council (LLC); Town & Staff Meetings, Web Page.	Goal Sharing Program; Decision Support Objects; Veteran Service Meetings; Staff Performance Standards; High Performance Development Model; Individual Development Plans; Employee Orientation; Employee Newsletter, Web Page.
Performance Expectations	Quantifiable performance measures linked to Critical Success Factors; Employee Performance Standards; Establishment of Projections using private sector benchmarks	Performance measures and expectations are communicated at Executive Leadership Council, Local Leadership, Union Meetings, Staff Meetings & Town Forums to reach front line staff.	Network, Care Line & Medical Center; Goal Sharing; Staff Performance Standards; HPDM; Performance results posted in Pulse Points & Decision Support Objects (DSOs); Employee Orientation
Value for Patients & Stakeholders	Patients, Veterans Service Organizations, Labor & Community partners assist in developing Critical Success factors. Multiple listening & learning posts; Performance measures ensure balance between customer & stakeholder needs.	Patients and Stakeholders are members of various councils including, ELC, Community Advisory Boards, Management Advisory Council (MAC), and the Union Council. Senior leaders utilize the MAC and Community Advisory Board as a marketing tool to communicate changes or improvements in services and benefits.	Annual *Report to the Community* highlights programs and performance on key business drivers and patient/stakeholder expectations; Quarterly Patient Newsletter highlights new, or changes in, processes, benefits, & programs. Hardcopy reports of each are mailed to veterans and stakeholders.

Fig. 1.4

organizational goals. Senior leaders' direct involvement in promoting values and expectations are presented in **Fig.1.4.**

The Executive Leadership Council Web Page, contains an Employee Collaboration Tool to solicit input from staff. **(Fig. 7.3A-B)** A Strategic Planning Web page similarly solicits employee involvement in developing goals and programs. Achieving 100% staff involvement in Goal Sharing (winning OPM's Pillar Award), the introduction of an ELC and Strategic Planning websites for employees, and performance results at the highest level of the VA, are testimony to senior leaders' involvement in Network 2 goals. Crucial to organizational success is an advanced data system, Decision Support Objects (DSOs), developed by VISN 2, allowing staff to instantly evaluate organizational progress for over 100 data elements. **(Fig. 4.4)**

1.1a(2) Empowerment, Innovation &Learning: Network 2's successes since 1996 are rooted in the wide deployment of performance goals, with the expectation that line staff become the primary participants in improving processes. This empowerment is evident through front-line driven innovations resulting in the 2001 Labor-Management Cooperation Award, the 2001 Undersecretary's Award for Innovation, for our On-Demand Learning System, and our unique Goal Sharing Program, all of which were developed by staff. Goal Sharing **(Fig 2.7)** induces front-line development of local goals. All 5000 employees participate in over 1000 teams in support of the organizational direction. Empowerment is illustrated in **Fig. 1.5.**

Fig. 1.5

Network 2 leaders quickly respond to changing needs of customers and/or health care trends, by creating an environment for organizational and staff learning at the work unit levels. Organizational learning opportunities are identified through patient and stakeholder feedback, research activities, analysis of performance measure results and accreditation reviews. **(Fig 1.6)**.

Through staff meetings, committee involvement and employee suggestion programs, our staff are encouraged to share ideas and best practices to identify opportunities for improvement and to generate innovative solutions. Patient feedback sets direction for improved delivery practices including

reduced clinic-waiting times, appointments within 30 days, and improved access to care through new Community Based Outpatient Clinics (CBOC). Network 2 achieved VA's highest satisfaction scores for access to care, clinic waiting times, specialty care and Home-based Primary Care (HBPC) with overall outpatient satisfaction equaled 70.1%, the 2nd best among 22 VA networks. This compares favorably against the highest rated HMOs in New York State **(Fig 7.1Q).**

Our senior leaders facilitate learning through diverse means as described in **Fig 1.6.**

1.1b(1) Organizational Performance Review: Senior leaders, in support of the goal of achieving the highest measurable levels of quality and satisfaction, establish and review key performance measures. **(Fig. 2.9)** Sources of information include analysis of prior performance measure results, cost, workload and quality data, customer feedback, and analysis of the internal and external environment. Senior leaders review feedback reports from prior Kizer, Carey and Baldrige applications in order to modify the current strategic direction or improve current processes. Planning input is broadly solicited from patients and stakeholders through the Network

SENIOR LEADERS-LEARNING & EMPOWERMENT

	Senior Leaders:	Application/Initiative:
Reinforce Empowerment and Innovation	ˇ Staff participation on local & network committees ˇ Network Councils empowered to set direction ˇ Employees empowered to resolve complaints ˇ Brainstorming Retreats ˇ Research & Benchmark comparisons ˇ Systems review & development of creative solutions ˇ Continuous evaluation of key/support processes Fig. 6.1	ˇ Community Based Clinics ˇ IHI Collaborative - Waits & Delays ˇ Customer Service Council established ˇ Veterans Service Center established ˇ Phantom Shopper initiated ˇ Greeter Program initiated ˇ Goal sharing Program implemented
Encourage Organizational Learning	ˇ Continuous analysis of performance measures results ˇ Sharing of information/knowledge ˇ Embrace CQI principles ˇ Celebrate Successes ˇ Recognize & learn from Noble Failures ˇ Identification & Deployment of Best Practices ˇ Patient & Stakeholder Feedback ˇ Comparisons to Benchmarks	ˇ Best Practice Deployment of CDI/PI ˇ Feedback reports: Carey & QARG ˇ Goal sharing Program ˇ Root Cause Analysis Process ˇ Interactive Planning Process ˇ IHI Collaborative – Waits & Delays ˇ Pulse Points ˇ Decision Support Objects
Encourage Staff Learning	ˇ Sharing of knowledge and expertise ˇ Dedicated Funds for educational opportunities ˇ Establishment of a Network Education Council ˇ Deployment of HPDM/core competencies ˇ 360 Evaluations ˇ Continuing Education as a key support process	ˇ Continuing Education Performance Standard ˇ On the job training forums ˇ Staff meetings/committee involvement ˇ Coaching & Mentoring Program ˇ Employee Newsletter ˇ Individual Development Plans (IDPs)

Fig. 1.6

Employee Individual Development Plans (IDPs) are encouraged to strengthen the skills of our staff. Senior leaders support an interactive strategic planning process, involving a maximum number of staff at every level within the Network **(Figs 2.3).** Network 2's successful transformation from a hospital-based system to an integrated health care network is a result of a participative planning process involving all employees and leaders. Assuring maximum staff development is crucial to Network 2's continued success. Staff Development Principles, practiced daily by senior leaders, are identified in **Fig 1.7.**

OPTIMUM STAFF DEVELOPMENT

- CONTINUING EDUCATION
- EMPOWERMENT TO TAKE ACTIONS
- HIGH PERFORMANCE DEVELOPMENT MODEL
- GOAL SHARING PROGRAM
- INTERACTIVE PLANNING
- COACHING & MENTORING
- WEB-BASED EMPLOYEE COLLABORATION TOOL
- REWARD & RECOGNITION

Fig. 1.7

2 Website, town meetings, labor meetings, forums with veteran service organizations, and congressional representatives. Primary responsibility for setting organizational direction and identifying potential opportunities resides with the Executive Leadership Council. Council membership consists of representation from internal and external stakeholders, labor, veterans groups, Director of Veterans Benefits and senior leadership. The ELC develops the mission, vision, values and strategic objectives. A plan has been established to guide Network 2 toward world-class status as illustrated in **Fig 1.9.** Unlike other organizations, which deploy goals set by senior leaders, Network 2 has proactively sought to involve staff in the actual formulation of the strategic direction. Performance measures, linked to critical success factors, are established to evaluate organizational effectiveness **(Fig 1.8)**

Network 2 relies on state of the art data generation tools to provide data and information for all major

SENIOR LEADERS PERFORMANCE MEASURE REVIEWS

Critical Success Factors	Performance Measures	2001 Results	Evaluation/Magnitude of Improvement	Reviewed By Whom
Excellence in Quality of Care	•**Clinical Practice Guidelines** •**Prevention Index** •**Mental Health Follow-up**	Quadrant 1 81% 97.6%	♦ Exceptional Rating; Improved from Quadrant 2 in 2000; VA Best in Diabetes Foot Exam & Maj Depression Screening; surpassed private sector norms (Section 7.1) ♦ Increased from baseline 72% in 2000; VA best in Colorectal Screening, ♦ VA Best for 3 Years (1999-2001)	Reviewed by ELC, LLC, Providers, Performance Management, Employees
Veteran Satisfaction	•**Overall Satisfaction (Fig 7.1 A)** •**Waiting Time Satisfaction** •**Waiting Times in Days**	70.1% 83% 5 clinics <30 days	♦ 2nd Best among 22 VA Networks; approaching U.S. & NY State best HMO (74%)Cap Dist Physician's Health Plan ♦ •VA's highest satisfaction for Waiting Times. ♦ Exceptional performance level for Primary Care, Audiology, Cardiology, Ortho. & Urology	Reviewed by ELC, TSPQ, LLC, Customer Service Council, Employees
Health Care Value	•**Cost per Patient** (•**Staffing per Patient** •**Acute bed days of Care per 1000 Pt**s (Fig 7.2P)	$4,133 41.5 789.3	♦ VA's 4th lowest cost; 15% below. U.S. HMO mean; 23% below Medicare cost per enrollee ♦ Greatest increase in productivity among 22 VA networks ♦ 6th lowest rate among 22 networks, 10% reduction since 2000; 51% below Medicare rate	Reviewed by ELC, TSPQ, LLC
Patient Growth	•**Veteran Market Penetration** •**Cat A Veteran Market Pen.** •**Annual Market % Growth**	20.5% 39.5% 13.2%	♦ 3rd highest penetration among 22 VA Networks ♦ 4th highest Cat A penetration nationally ♦ Surpassed For profit, Non Profit and Govt 75th percentile	Reviewed by ELC, TSPQ, LLC

Fig. 1.8

areas of organizational performance, i.e., Decision Support Objects and Pulse Points.

These data sources provide cumulative monthly updates and performance data for the past 3 fiscal years. Using the process described in **Fig 6.1,** senior leaders review this data monthly to assess organizational performance and progress, and to identify opportunities for improvement. Performance measure results are analyzed at the Network and medical center levels. Trends in Network performance are identified and compared to rankings among all 22 Networks nationwide, the Best Practice Network and private sector best performers.

1.1b(2) Findings & Priorities for Improvement*:* Monthly analysis of key performance measure findings drive the establishment of action plans for areas of improvement. Discussion of results at ELC and TSPQ enable senior leaders to set priorities for improvement. Priorities are ranked based on patient needs and availability of resources. Competing priorities are ranked based on the degree of impact and value to patients. Performance improvement priorities are communicated to process champions for the development of solutions and associated action plans. **(Fig 6.1.)**

Performance indicators address each of the critical success factors and are deployed throughout the organization through monthly analysis of cost, workload and quality data. Results and priorities are made available to leaders and staff through Pulse Points, DSOs, employee newsletters, Town meetings, and the Network 2 Web page. Patients and stakeholders receive performance information via the Network Web page, the *Report to the Community*, Veterans Wellness Newsletter and through ELC and Management Advisory Council participation.

Recent results for key performance measures are presented in **Fig. 1.8**. Senior Leaders have designed a set of strategies for achieving sustained superior performance as illustrated in **Fig. 1.9.**

Fig. 1.9

Best practice solutions were communicated and deployed resulting in measurable improvements in health care quality indices. **(Figs. 7.1A-P)** Future goals are described in **Fig 2.6, 2.10, Cat 2.2a(1)** and include increasing patients served, reducing waits and delays for outpatient care, and improving adherence to evidence-based, clinical practice guidelines.

1.1b(3) Improving Leadership Effectiveness: Our senior leaders continually seek opportunities to improve their effectiveness through daily communication with staff, examination of relevant performance measures, and through "360 degree" evaluations. Through the evaluation program, each executive receives confidential scores and verbal comments from about 20 internal customers, subordinates and peers. **(Fig. 1.10)** Techniques are specifically chosen to improve performance by encouraging innovation and empowerment among staff and by applying lessons learned. **(Fig. 6.1)** Notable areas of improved leadership effectiveness include clinic timeliness **(Fig. 7.1A&B)**, C&P exam **(Fig. 7.4D)** and sufficiency and overall quality improvement scores. **(Figs. 7.1A-P)** Staff feedback from Town Meetings, employee suggestion programs, web site questionnaires, and informal conversations are used to assess leadership effectiveness. Senior leaders use this feedback to improve their leadership and communication skills and to develop Individual Development Plans. In addition, the High Performance Development Model is used to assess leader effectiveness for 5 core competencies. **(Fig. 7.3I)**
Leadership Performance Improvement is illustrated in **Fig. 1.10**.

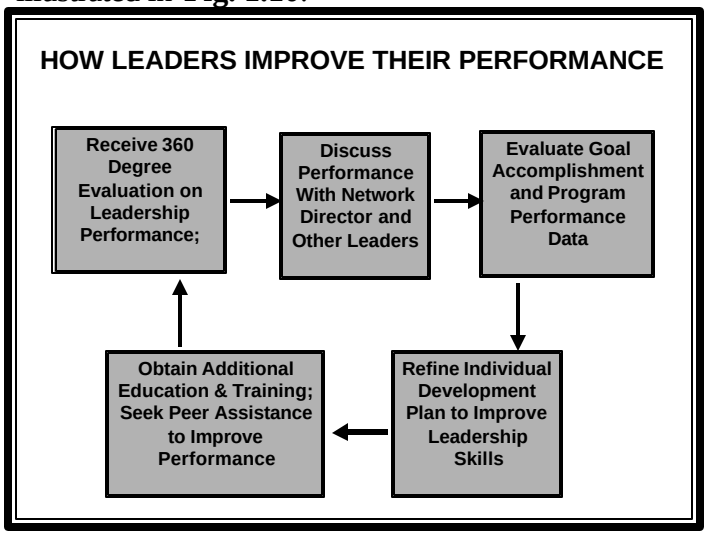


Fig. 1.10

1.2 Public Responsibility and Citizenship
1.2a(1) Societal Requirements: Network 2 provides healthcare to over 120,000 veterans across Upstate New York , provides numerous medical training opportunities, and serves as primary back up to the Department of Defense for emergency preparedness. In maintaining numerous accreditations, Network 2 is inviting outside regulatory agencies to perform independent review of its healthcare practices. Network 2 is an agency of the U.S. Department of Veterans Affairs (VA). As such, it operates under the rules and regulations promulgated by VA and other applicable federal laws. Any claims for alleged torts, including medical malpractice, are handled pursuant to the provision of the Federal Tort Claims Act, 28 U.S. Code, Section 2671. Network 2 has integrated all risk related programs under the Performance Management Service Line including the Patient Incident Reporting Program, Administrative Investigations, Medical Device Incident Reporting, Occurrence Screening and Tort Claims. The Risk Management program supports a framework for activities including the Patient Advocate Program, Customer Satisfaction, Credentialing and Privileging, the National Practitioner Data Bank, Utilization Review, Infection Control, Safety and Health Program, Review of Rejected Applications and Informed Consent. **Fig 1.11** illustrates how Network 2 meets its responsibility to the public.

1.2a(2) Anticipating Public Concerns: Network 2 maintains open communications with stakeholders through the Management Assistance Council (MAC), Congressional briefings, the Network 2 ELC, and local medical center consumer councils. Governor Pataki's Director of Veterans Affairs is a member of the ELC. This engenders open discussion, providing forums for identification of community concerns and obtaining pre-decisional input on planned initiatives. Network 2 membership on various healthcare organizations such as the National Chronic Care Consortium and the Health Care Advisory Board assists Network 2 in identifying current and future needs. Network 2 employees maintain membership in numerous professional societies including the American College of Healthcare Executives, the American Medical Association as well as numerous professional and allied health organizations.

1.2a(3) Ethical Practices: Network 2 has established and implemented a code of behavior for employees to provide a consistent, ethical framework for patient care and business operations. It has established a Statement of Organizational Ethics in recognition of the ethical responsibility that a health care organization has to organizations through "Stand Downs". Network 2 shares technical expertise, educational resources, and community support mechanisms with the Upstate New York Alzheimers Association, targeting support for veterans, non-veteran caregivers and their families. Leadership's involvement in support of key communities is illustrated in **Fig. 1.11**.

PUBLIC RESPONSIBILITY & CITIZENSHIP

SOCIAL	NETWORK PRACTICE	MEASURE	TARGET
Maintain Quality Health Care	•JCAHO Accreditation •NCQA Accreditation •College of American Pathologists Accreditation •CARF Accreditations •Credentialing, Privileging, Reappraisal & Re-privileging Process	•5 of 5 medical centers -3-year JCAHO Accred. •Network-wide NCQA accreditation •Laboratory facilities to achieve CAP accreditation •Behavioral Health and Rehabilitation Programs hold CARF accreditations •Licensed independent practitioners are subject to credentialing and privileging	•Accreditation Score of ≥ 90 •2-Year Accreditation w/ commendation •Five of Five Labs are CAP Accredited •3 Behavioral Health programs and 1 Physical Rehab Medicine program are CARF Accredited •All new hires credentialed & privileged; current practitioners re-credentialed and re-privileged every 2 years thereafter
Support Medical Education	•Academic Affiliations •Resident & Allied Health Professional Training	•Medical centers maintain affiliations with medical schools and allied health organizations •Residents, health professionals trained	•5 of 5 medical centers maintain affiliations •703 Residents, 1496 health professionals trained in FY00
Build Healthy Communities	•Community Health Fairs •Response to Sept 11th Terrorist Attacks •Capital Asset Review(CARES) •Network Emergency Preparedness Plan	•Participation in community-wide health fairs at all five medical centers •Staff Detailed to New York City •Develop alternate uses for unused buildings-homeless veterans •Emergency Preparedness Plan serves the VA and the community	•Over 100 Health Fairs Held at all Medical Centers during FY00 •Canandaigua & Batavia projects to create housing for low income & homeless veterans •Annual emergency preparedness exercises & quarterly reviews of emergency preparedness initiatives

Fig. 1.11

the patients and community it serves. Network 2 has also published its policy and procedure defining the rights and responsibilities of patients. These rights and responsibilities are located in all patient care areas, patient handbooks, and patient information binders.

1.2b Support of Key Communities & Community Health: Community areas of need are identified through the multiple feedback sources used in the strategic planning process and in setting organizational goals. **(Fig. 2.4)** Network 2 has an active Speakers Bureau with professional staff presenting at schools, community organizations, and other healthcare organizations to speak on various healthcare issues of interest. Network 2 employees serve on a number of community and charitable projects including the Combined Federal Campaign and the VA National Golden Age Games. Outreach efforts to the homeless in Network 2 are conducted in partnership with community

Network 2 maintains an influential role within the communities of Upstate New York, contributing to the improved well being of veterans and the general public. Offices of county veterans' service officers' are co-located in many CBOCs, both VA and contractor. Through a growing number of community partnerships, VISN 2 shares medical and health care expertise, provides screening and treatment programs and leads in establishing networks of community education providers. All sites have compiled and distributed information on available wellness resources, and wellness centers are planned at all sites. Network 2 assumes a leadership position throughout Upstate New York with regard to homeless programs, dementia and Alzheimer's care, Post Traumatic Stress Disorder, Prosthetics and Rehabilitation. Veterans in need of substance abuse services are referred to our Domiciliary Rehabilitation programs from other networks.

2.0 STRATEGIC PLANNING

2.1 Strategic Development: Strategic Planning permeates all aspects of our organization, assuring universal staff involvement and empowerment, while continually assessing and refining health care services. Thorough a customer-focused, staff driven process, we are able to meet rapidly changing needs and customer requirements.

2.1a(1) Strategy Development Process: The Strategy Development process defines Network 2's immediate and future plans to provide high quality services to the veteran population. Our organization has introduced the following principles which guide the Strategic Planning process **(Fig 2.1):**

STRATEGIC PLANNING PRINCIPLES FOR SUPERIOR PERFORMANCE

- SET PERFORMANCE EXPECTATIONS THAT FAR SURPASS ALL CURRENT HEALTH SYSTEMS (90th Percentile in Patient Satisfaction & Quality Scores)
- BENCHMARK WITH THE BEST HEALTH CARE & NON-HEALTH CARE ORGANIZATIONS
- GAIN FULL STAFF PARTICIPATION IN STRATEGIC PLANNING THROUGH GOAL SHARING & INTERACTIVE PLANNING
- MONITOR & COMMUNICATE PERFORMANCE ACHIEVEMENT THROUGH THE MOST ADVANCED DATA SYSTEMS
- EMPOWER ALL STAFF THROUGH SELF-DIRECTED ACTIONS

Fig 2.1

Crucial to the development of short and long range goals and objectives is the establishment of measurable performance targets for key determinants of organizational success **(Fig. 2.9)**. The strategic planning process incorporates information from patients including customer satisfaction surveys, and financial and performance data in the formulation of strategic objectives. This participative process involves all levels of the organization including front line as well as senior leadership in the formulation of goals and associated strategies. The process is illustrated in **Fig. 2.2**:

Network 2 applies an Interactive Planning Process through which staff at all levels of the organization participate in formulating the organization's future. As a vital component of the planning process, Care Lines and key program areas participate in a series of visioning exercises, through which a desired future is developed, along with corresponding strategies.

Interactive Planning is based upon the concept that the more staff participating in the process, the greater the likelihood that plans will be successfully implemented through widespread ownership of outcomes **(Fig. 2.3)**:

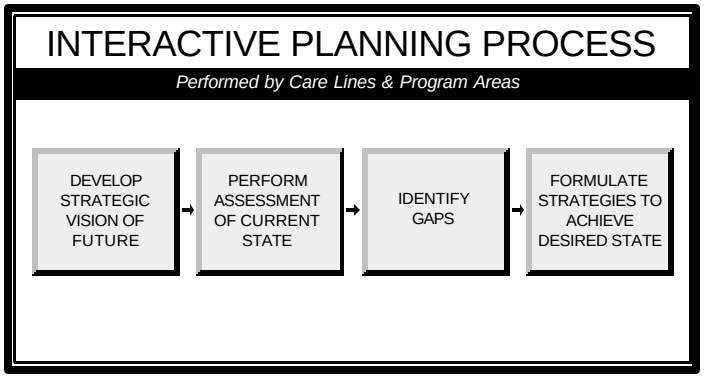


Fig 2.3

Care lines and key program areas develop strategic objectives in support of each of VHA's Six for 2006 Goals, including quantifiable performance measures to accurately gauge achievement. Primary responsibility for strategic planning resides with the Network ELC which serves as the governing body for Network 2. Network planning staff are responsible for implementing the steps of the strategic planning process, for providing workload and financial data and for leading in the development of goals and objectives. Care Line Managers and Medical Center Directors are responsible for broad solicitation of input from all levels of the organization, towards the formulation of operational strategies.

Network 2 applies information from a wide array of stakeholder groups in the formulation of organizational goals and operational objectives.**(Fig. 2.4)**

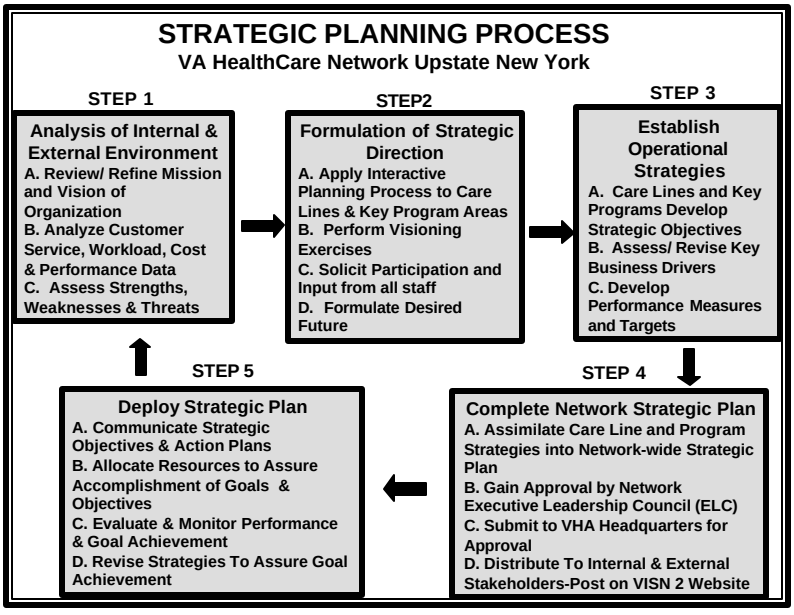


Fig 2.2

Forums include the ELC, composed of Network and Medical Center staff, veteran service organizations, union representatives and community leaders **(Fig 1.4)**. The Union and Management Assistance Councils, composed of a wide array of network stakeholders, also provide valuable information in formulating organizational policy. Meetings with veteran service organizations and congressional representatives are held throughout the year at respective medical center locations, with information incorporated at the local and network levels.

2.1a(2) Consideration of Key Factors:
The Network 2 Strategic Planning process incorporates a full range of information in determining strategic goals and operational objectives. Sources of information encompass key data related to cost, workload and productivity, customer feedback from all levels of the organization, analyses of the internal and external environment including financial risks and market competition. Planning input is broadly solicited from constituents through the Network 2 Website, Town Meetings and through forums with veteran service organizations and congressional representatives **(Fig 1.4)**. Key Factors are described in **Fig. 2.4**.

2.1b Strategic Objectives:
2.1b(1) Accomplishing Strategic Objectives:
Strategic Objectives are developed by each Care Line and program area in accordance with VHA's Six for 2006 goals and four critical success factors, through the Interactive Planning Process **(Fig. 2.3)**.

KEY FACTORS CONSIDERED IN STRATEGIC PLANNING

Key Factors	Strategy
Customer Needs and Expectations	♦ Solicitation and application of feedback from diverse stakeholder groups. ♦ Development and implementation, by the Network Customer Service Council, of the Network consult response time and Network clinic cancellation policies. ♦ Network-Wide implementation of the Quick Card Program(recently recognized as a VA Best Practice). ♦ Creation of the Internal Shopper, Patient Pager and Greeter Programs.
Competitive Environment-Financial & Other Risks	♦ Evaluation of Network 2's position relative to the health care environment. ♦ Analysis of financial risk-potential and strategies to produce financial turnaround. ♦ Evaluation of available community resources to support "make vs. buy" decisions. ♦ Analysis of Community Based Clinic decisions for each new site – considers capacity and quality of community providers, potential for partnerships with area providers, volume of potential patients served. ♦ Analysis led to a decision for a VA extended care facility to partner with a nearby community hospital.
New Technologies	♦ Assessment of new technology by the Network Medical Director and the appropriate oversight group as determined by the Network Medical Director. Examples of new technology include: Barcode Medication System (BCMA), Vista Imaging, and Telemedicine. ♦ Annual equipment/technology assessment to prioritize current capability.
Human Resource Capabilities & Needs	♦ Identification of employee needs in accordance with Care Line programs and strategies. ♦ Assessment of staffing levels and types of positions needed and develop performance appraisal plans to ensure competency requirements are met. ♦ Annual employee evaluation performed to ensure a competent workforce. ♦ Annual Employee Learning Needs Assessment is utilized to identify skills training and related education required. ♦ VHA's High Performance Development Model (HPDM) is aligned with VISN 2's strategic direction to develop and maintain a highly skilled work force.
Operational capabilities	♦ Application of Best Practice and Lessons Learned as a means to rapid organizational improvement. ♦ Charter Strategic Information Council (SIC) to assess information system capability. ♦ VISN Research Advisory Council to evaluate, plan, and set research priorities.
Supplier & Partner Capabilities and Needs	Strategic partnering and supplier agreements utilized to provide effective Network services: ♦ Negotiation of expected capability with partners through written agreements. (Example-Prime Vendor Program developed with selected suppliers (see Process Management)). ♦ Collaboration with Centralized Mailout Pharmacy (CMOP) to continually assess and improve pharmacy services provided to customers. ♦ Network CBOC Committee monitors and provides feedback to contract staff, and provides continual training on CBOC patient care requirements
Customer Needs and Expectations	Solicitation and application of feedback from diverse stakeholder groups. Development and implementation, by the Network Customer Service Council, of the Network consult response time and Network clinic cancellation policies. Network-Wide implementation of the Quick Card Program(recently recognized as a VA Best Practice). Creation of the Internal Shopper, Patient Pager and Greeter Programs.

Measurable targets in association with organizational goals are identified in **(Figs. 2.5&2.9)**. Customer service needs are fully incorporated into the development of strategic objectives, with new products and services created as a result of this process.
Organizational results have been linked to each identified performance measure in **Figs. 1.9&2.9**.

Network 2 has developed strategic objectives and performance measures in support of VHA's Six for 2006 Goals **(Fig. 2.5)**. Critical Success Factors have been aligned with VHA's Six for 2006 Goals and Network 2's strategic objectives. Timetables for achieving performance targets are provided in **Fig. 2.9**.

KEY STRATEGIC OBJECTIVES

VHA'S SIX FOR 2006	NETWORK 2's 4 CRITICAL SUCCESS FACTORS	STRATEGIC OBJECTIVES
I. Put Quality First Until First in Quality	**1. Excellence in Quality**	Surpass 90th Percentile nationally for recommended clinical interventions and prevention screening
II. Easy Access to Medical Knowledge, Expertise & Care	**2. Outstanding Customer Service** **4. Significant Patient Growth**	Achieve <30 day waits for primary care & specialty clinics; Achieve <20 minute waits for appointments; Provide excellent telephone care (fewest complaints); Expand Telemedicine & Telepsychiatry
III. Enhance, Preserve, and Restore Patient Function	**1. Excellence in Quality** **2. Outstanding Customer Service**	Reduce amputations and implement case management for diabetic patients; Adhere to Clinical Guidelines for Post Stroke Patients; Foster Health Promotion for Frail Elderly, Provide Dementia Care
IV. Exceed Patients' Expectations	**1. Outstanding Customer Service**	Surpass U.S & NY State HMO norms for Patient Satisfaction; Surpass existing standards for clinic waiting times
V. Maximize Resource Use to Benefit Veterans	**3. Optimum Health Care Value**	Achieve optimum cost and staffing levels per patient; Maximize Alternate Revenue
VI. Build Healthy Communities	**1. Excellence in Quality**	Develop Wellness & Prevention Initiatives; Increase Research Expenditures; Participate in National Alzheimer's Project

Fig. 2.5

2.1b(2) Addressing Challenges of Organizational Profile: Strategic objectives have been aligned with challenges outlined on page v. of the organizational profile, with specific attention to generating patient growth in an area of declining veteran population. We have identified patient growth as one of our four critical success factors and have established growth targets to maximize reimbursement under VA's VERA funding model.(**Fig. 2.9**) For these growth objectives to be achieved, we strive to balance our growth targets with patient satisfaction and timeliness targets at the highest level of the health care industry, comparing our performance to the best among all U.S. and NY State HMOs. This will increase the likelihood that veterans will choose and remain with our system for their health care needs.

2.2 Strategy Deployment

2.2a(1) Development of Action Plans: Network 2 Action Plans are established in accordance with the Care Line and Network strategic objectives and approved through the ELC. Timeframes for completion are developed to include responsible officials, status reports and dissemination of information.

Key Action Plans encompass plans for the continued transformation of the health delivery system, to achieve measurable improvements in quality and customer satisfaction, while continuing to expand service connected or low-income veteran market penetration to above 42% by 2002, thereby offsetting population losses. This will be accomplished by introducing initiatives to improve access to care and information, including the integration of behavioral health and geriatric services at community based clinics, continued development of the Veteran Service Centers and the Knowledge Management Office, and through enhanced clinic scheduling processes. Other action plans include participation with the Institute for Health Care Improvement (IHI) Collaborative to reduce clinic waiting times **(Fig. 7.4 A&B)**, continued standardization of care through disease management programs including improved compliance with clinical guidelines and preventive indices **(Fig7.1A-P)**. Network 2 has undergone integration of its patient data base among all facilities, to improve continuity of care and timely access to patient information from any location. Long-range action plans encompass application of telemedicine at all sites consisting of universal

computerization of medical records including computer imaging, and enhancements of physical plant to provide state of the art clinical facilities. Additional action plans include the continued integration of behavioral health and geriatric services within primary care clinics, development of two exam rooms per provider to expand accessibility, and process improvements to achieve 48 hour turnaround time for eyeglasses. Short and long range action plans are presented in **Fig. 2.6**:

SELECTED SHORT & LONG TERM ACTION PLANS

Critical Success Factor	Short Term Action Plans (2002-2003)	Long Term Action Plans (2004-2006)
Excellence in Quality Outstanding Customer Service	♦ Create Diabetic Management Program ♦ Apply Clinical Reminders for Performance Indicators ♦ Conduct Health Promotion for Frail Elderly ♦ Implement Case Management at each Site ♦ Participate In IHI Collaborative To Improve Waiting Times ♦ Surpass 20 minute waiting time through scheduling improvements ♦ Conduct Greeter & Internal Shopper Programs ♦ Provide customer service training for front-line staff	♦ Develop Wellness Centers at all Sites ♦ Develop Full Electronic Medical Record ♦ Implement Clinical Imaging, Telemedicine/ Telepsychiatry at all sites ♦ Modernize Outpatient Clinics to Enhance Privacy and Patient Flow ♦ Develop Health Care Malls at all Sites ♦ Establish Excellent Patient Transportation System among Sites
Optimum Health Care Value	♦ Control Drug Costs Through Provider Profiling ♦ Expand Home And Adult Day Health Care Alternatives to Institutionalization ♦ Apply Actuarial Data to Improve Utilization	♦ Develop advanced resource allocation processes to include risk factors ♦ Manage High Risk Populations ♦ Redesign Work-unit Key Processes
Significant Patient Growth	♦ Conduct Health Fairs and Provide Direct Mailings To Veterans ♦ Perform Outreach To Minority Veterans ♦ Improve Patient Scheduling Process	♦ Surpass 50% Category A market penetration by 2005 ♦ Provide 60 minute/60 mile access to all specialties; 30 min/30 miles for Prim. Care

Fig. 2.6

Network 2 applies private sector best practices in strategic planning in order to improve all facets of the process including resulting outcomes. Concerns over clinic timeliness led to the establishment of 20 minute standards, with reports presented monthly to the Network ELC. The achievement of one integrated database has further improved data accessibility and timeliness of patient care delivery.

2.2a(3) Human Resource Requirements: Network 2, in partnership with labor unions, continues to align staff with programmatic objectives, with resources redirected to areas of greatest patient demand. Outpatient staffing enhancements, including Community Based Outpatient Clinics, home based and Adult Day Health Care Programs, will further improve veteran access to care and market share. Human Resource needs are determined based upon a workload driven financial model, through which care lines are funded in accordance with projected workload. This funding model applies a financial allotment per clinic stop, inpatient day or other appropriate workload unit across all patient care programs. Care Line budgets are further subdivided by medical center in proportion to planned program requirements and projected workload. The FY 2002 Budget has been developed by Care Line in accordance with workload forecasts and related strategic initiatives.

2.2.a(4) Key Performance Measures: Key performance measures have been established in accordance with Network 2's Critical Success Factors. **(Fig. 2.9)** Progress is monitored through monthly analysis of cost, workload and quality performance data. Information is made available to staff at the Medical Center as well as the Network level. Monthly reports are provided to the ELC to assess performance, through which required action is directed in accordance with targeted goals. Performance is made available to Network 2 stakeholders through ongoing posting of information on the Network 2 Web page. Goal sharing programs have been established in concert with the deployment of the Network Strategic Plan, to assure universal employee involvement in pursuing organizational strategies as illustrated in **Fig 2.7:** Comparative performance among community and VA providers is shown in **Fig1.8**.

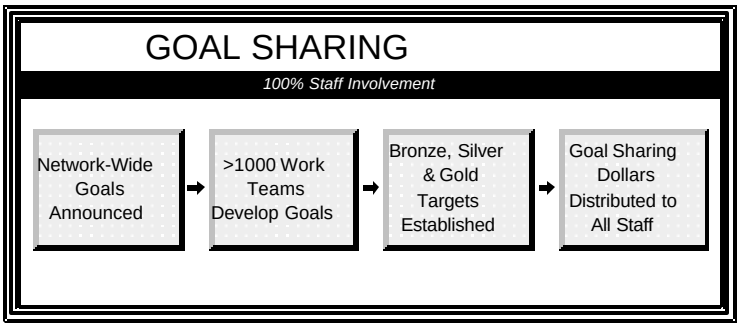


Fig 2.7

2.2b Performance Projections: Network 2 compares its performance with the best HMOs nationally in setting performance targets. **(Fig 2.8)** Performance projections have been established to achieve sustained excellence in all facets of organizational performance, in accordance with our four Critical Success Factors. Network 2 achieved

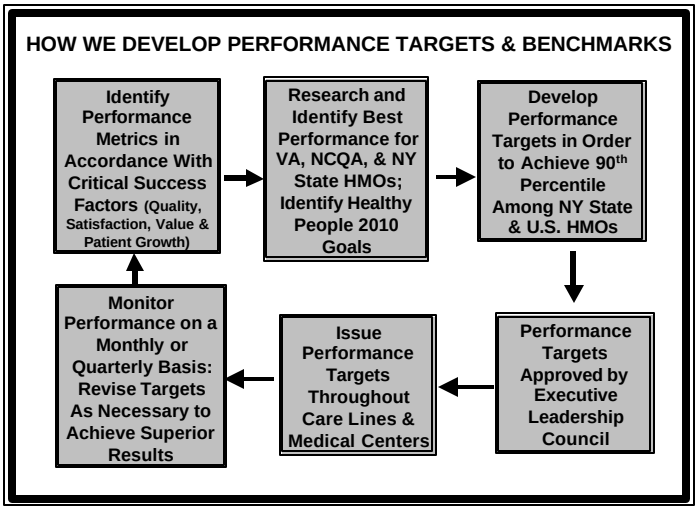


Fig. 2.8

or approached VA best practice in each of the four areas deemed crucial to organizational success (Critical Success Factors), while approaching performance of the best health care systems in the United States. Performance projections have been designed to assure that Network 2 achieves and sustains results at the highest level of the VA and health care industry. Projections through 2006 are included with VA best and private sector benchmarks identified in **Fig. 2.9.** We use current NCQA and HMO national results in combination with Healthy People 2010 goals to set performance projections through 2006.

PERFORMANCE PROJECTIONS FOR KEY MEASURES

		ACTUAL				PROJECTIONS					
Critical Success Factor	Key Measure	2000	2001	VA BEST	Private Sector	2002	2003	2004	2005	World Class Target-90th Percentile	2006
QUALITY	Influenza Immunization	60.0%	70.0%	*77%-VISN 19*	*87.6%-NY HMO Best; Healthy People 2010-90%*	75.0%	78.0%	81.0%	85.0%	90.0%	92.0%
	Colorectal Cancer Screening	55.0%	69.0%	*69%-VISN 2*	*Healthy People 2010-85%*	72.0%	74.0%	78.0%	81.0%	85.0%	90.0%
	Mammography Screening	NA	79.0%	*89%-VISN 22*	*82%-NCQA 90th%; Healthy People 2010-85%*	85.0%	88.0%	91.0%	92.0%	93.0%	94.0%
	Cervical Cancer Screening	84.0%	89.0%	*94%-VISNs 19 & 21*	*83%-NCQA 90th% Healthy People 2010-85%*	93.0%	94.0%	95.0%	96.0%	97.0%	98.0%
	Pneuomococcal Immunization	71.0%	79.0%	*89%-VISN 16*	*Healthy People 2010-90%*	85.0%	89.0%	90.0%	91.0%	92.0%	93.0%
	Alcohol Screening	67.0%	79.0%	*85%-VISNs21 & 10*		83.0%	85.0%	87.0%	88.0%	90.0%	92.0%
	Tobacco Screening	93.0%	97.0%	*98%-VISN 2*	*Healthy People 2010-85%*	98.5%	99.0%	99.0%	99.0%	99.0%	99.5%
	Mental Health Follow Up	96.1%	97.6%	*97.6-VISN 2*	*82.2%- NY HMO Best*	98.0%	98.2%	98.4%	98.6%	98.0%	99.0%
	Major Depression Screening	84.0%	89.0%	*89%-VISN 2*	*Not Measured by NCQA Healthy People 2010 Treatment Goal=50%*	90.0%	91.0%	92.0%	93.0%	90.0%	94.0%
	Aspirin Administration	77.0%	80.0%	*93%-VISN 21*		88.0%	92.0%	93.0%	94.0%	94.0%	95.0%
	Beta-Blocker (most recent visit)	70.0%	71.0%	*83%-VISN 1*	*98%-NCQA-90th %*	80.0%	85.0%	90.0%	94.0%	99.0%	99.0%
	Hypertension (BP <140/90)	49.0%	53.0%	*56%-VISN 13*	*47.9%-NCQA 90th % Healthy People 2010-50%*	56.0%	58.0%	60.0%	62.0%	64.0%	65.0%
	CHF Inpt with Eject Fraction	87.0%	87.0%	*96%-VISN 14*		92.0%	94.0%	95.0%	96.0%	98.0%	98.0%
	Diabetes Foot Sensory Exam	74.0%	83.0%	*83%-VISNs 2,15,20*	*Healthy People 2010-75%*	85.0%	88.0%	90.0%	91.0%	93.0%	94.0%
	Diabetes Retinal Eye Exam	51.0%	59.0%	*76%-VISN 20*	*66% -NCQA-90th% Healthy People 2010-75%*	70.0%	76.0%	95.0%	96.0%	97.0%	98.0%
SATISFACTION	Patient Satisfaction % VG/ Exc.	70.4%	70.1%	*71%-VISN 1*	*74.9%-NY HMO Best*	72.0%	74.0%	76.0%	79.0%	80.0%	82.0%
	% Patients Waiting > 20 Minutes	18%	17%	*17%-VISN 2*	*NA*	15.0%	14.0%	13.0%	12.0%	12.0%	10.0%
	Clinic Waiting Time (In Days)										
	Primary Care	46.4	33.4	*28.1-VISN 5*	*14.0-Wales*	28.0	21.0	15.0	10.0	9.0	7.0
	Eye	24.1	77.7	*25.7-VISN 5*	*28.0-Wales*	30.0	22.0	16.0	13.0	13.0	9.0
	Cardiology	22.6	29.6	*15.7-VISN 16*	*21.0-Wales*	28.0	21.0	15.0	10.0	9.0	7.0
	Orthopedics	34.1	20.7	*20.7-VISN 2*	*14.0-Wales*	20.0	16.0	14.0	12.0	12.0	9.0
	Urology	30.4	29.9	*17.6-VISN 5*	*21.0-Wales*	29.0	21.0	15.0	12.0	12.0	9.0
	Audiology	24.6	51.1	*13.6-VISN 16*	*NA*	30.0	22.0	15.0	12.0	12.0	9.0
VALUE	Cost per Patient	$4,011	$4,133	*$3632-VISN 8*	*NA*	$4,006	$3,976	$3,956	$3,936	$3,950	$3,930
	FTE per 1000 patients	42.7	41.5	*34.26-VISN 18*	*NA*	38.1	36.3	35.6	34.9	35.0	34.3
	Pharmacy Cost per Patient	$480.00	$545.00			$561	$589	$618	$649	$682	$716
	MCCF Collections	$16,167,023	$18,615,029	*NA*	*NA*	$19,906,279	$20,901,593	$21,946,673	$23,044,006	$24,196,207	$25,406,017
GROWTH	Category A Veteran Patients	82,482	86,011	*NA*	*NA*	93,003	99,344	105,305	110,570	114,993	119,017
	Category A Market Share	37.5%	39.5%	*44.67%-VISN 8*	*NA*	42.7%	46.2%	49.2%	52.2%	54.8%	56.7%
	Total Patients	116,556	125,453	*NA*	*NA*	132,445	138,786	146,419	153,740	159,121	163,895

Fig. 2.9

3.0 PATIENTS, OTHER CUSTOMERS AND MARKETS

3.1a(1) Patient Customer & Health Care Market Knowledge: Network 2's customer is the veteran in need of health care services. We have identified approximately 571, 000 veterans in the Upstate New York primary service area who are eligible for VA services, 218,000 of whom we have categorized as medically needy, our highest priority group. We continually evaluate veteran market penetration in reference to the total veteran population as well as the percentage of medically needy veterans treated **(Figs.7.2K&L)**. Network 2 segments its veteran patients by major markets, as determined by geographical locations throughout Upstate New York. In addition to segmenting markets to determine usage by location, we assess patient satisfaction by major market and refine services as necessary **(Figs. 7.2M&R)**. The Network Marketing Team and senior leaders analyze this data for planning and development of actions. **(7.1T&V)** Feedback from patients, Veteran Service Organizations and other stakeholders provides valuable information to leaders in determining target segments and the specific health care needs of these segments. This information is incorporated into strategic planning **(Fig. 2.1)** and key process development **(Cat 6.1)**.

Network 2 leaders assess demographic data to identify under-penetrated market segments. Based on this analysis, plans are developed to attract specific patient populations including women and seriously mentally ill patients. For example, information obtained from surveys and marketing fairs resulted in dedicated areas to meet the special health care needs of women patients in a private and comfortable setting.

Network 2's main competitors are those health care organizations in Upstate New York that provide services to veteran patients. Network 2 assesses growth in patient enrollment among state health maintenance organizations (HMOs), while also examining competitors' patient satisfaction and quality measures **(Figs.7.1Q, 7.2P)** to gain insight and improve competitiveness.

Our marketing team uses geographic location, market penetration and usage patterns to develop action plans focused on capturing current non-users. As a result, Network 2 has achieved best practice among 22 Networks for Access to Care since 1997 **(Fig. 7.1V)**. The Marketing Council has an ongoing working relationship with the New York State Department of Veterans Benefits to identify potential low-income veteran customers in order to provide information about available health care services.

3.1a(2)&(3) Listening & Learning: Detailed knowledge of customer and market segments enables Network 2 to tailor listening and learning strategies **(Fig. 3.1)** to support marketing efforts, develop new programs, improve health care and increase satisfaction. Data is integrated in the design model described in **Cat. 6.1** for developing or enhancing services based on identified customer needs and expectations. The Customer Service Council integrates the listening and learning findings with the Network Strategic Plan and uses aggregated data to formulate actions to improve

Listening & Learning Posts

LISTENING POSTS	LEARNING	APPLICATION OF LEARNING
Meetings with Veterans Service Officers *Current & Potential Pts*	Information enables VISN to learn about user/potential user preferences, expectations and obtain feedback on newly initiated programs or future programmatic changes.	Development of Community Based Clinics
Greeter Program *Current & Potential Pts*	Staff serve as daily 'eyes & ears' regarding needs/expectations of patients and customers.	Improved Signage across at all Health Care Sites
Internal Shopper Program *Current & Potential Pts*	Team of surveyors evaluate features important to patients and customers (courtesy, cleanliness, safety, parking, handicapped accessibility, etc.)	Development of Travel Lounge
Network 2 Web-site *Current & Potential Pts*	Direct user input is obtained on key requirements/needs.	Development of Virtual Help Desk
Quickcards & Other Satisfaction Surveys *Current & Potential Pts*	Opportunity for patients/family members to give feedback on their perceptions of the care and services rendered.	Deployment of waits & delays performance standards
Patient Advocacy Program *Current & Potential Pts*	Patient Representatives are highly visible and are a primary venue for obtaining complaints/input from veterans.	Development of Network Authorization Office
VISN 2 Marketing Team *Current & Potential Pts*	Direct user input is obtained on key requirements/needs.	Market to segments of veteran population, i.e, women, minorities
Questionnaires Surveys *Current & Potential Pts, Former Pts*	Surveys designed to seek feedback from recent encounters and also to ask patients why they have left VA Healthcare.	Development of Veterans Service Center

Fig. 3.1

health care and customer service.

A "Comping"/ Service recovery program has empowered staff to take required action, specifically at the front-line. **(Fig. 3.2)**

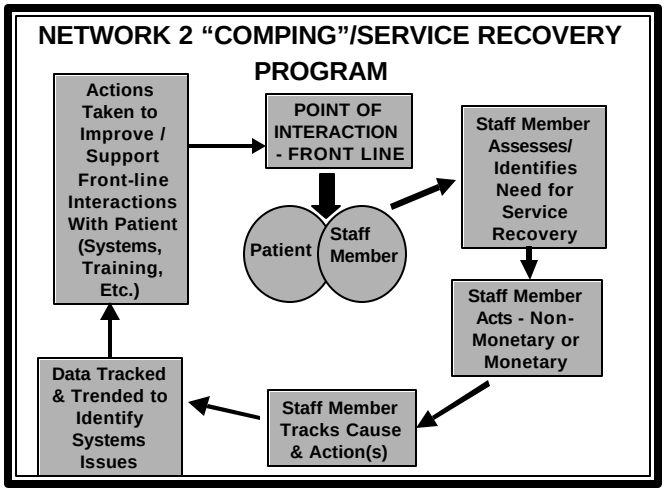


Fig. 3.2

3.1a(3) Network 2 recognizes that listening and learning techniques must be re-evaluated to keep current with customer requirements. Through patient and stakeholder input, Network 2 identifies opportunities to enhance listening techniques to yield quicker feedback and more meaningful information. Through ongoing input from veterans, patient satisfaction tools (Quick Cards) **(Figs. 7.AE-AH**) have been revised and ELC membership has been increased to include Veterans Service Organizations, union and veteran representatives to improve our listening capabilities.

For current and former patients, Network 2 determines key health care service features and their importance to our patients using the techniques described in **Fig. 3.3.** Surveys are mailed to non-users to assist leaders in understanding why veterans choose to use or not use Network 2 for health care services **(Fig. 7.1AB)** and are used in the planning process described in **Cat. 2.1**. It is also integrated in the design model described in **Cat. 6.1** for developing or enhancing services based on identified customer needs, health service feature expectations and critical success factors for using Network 2 for healthcare services. Leaders incorporate market penetration and retention data into this process. The Network 2 Customer Service Council, chaired by a Vice President for Customer Service, integrates the Listening & Learning findings with the Network Strategic Plan. Data is aggregated and analyzed using various tools including trending analysis and comparisons with best performers. The Customer Service Council uses this input to formulate actions to improve health care and customer service. Network 2's Marketing Council incorporates the new or enhanced health care services/features into the Network wide marketing plan to attract and retain patients. Through this process, Network 2 has identified the following service features important to patients: Pharmacy Benefits, female oriented health care service environments, smoking cessation programs, timely access to services and appointments, and the Telcare Hotline for providing health care advice. Veterans Service Centers also aid patients in accessing VA healthcare and inquiring about eligibility, benefits and services. We also include customer service topics in Network 2's employee newsletter to share information and progress on customer service initiatives with staff, patients and stakeholders.

3.2a(1&2) Customer Satisfaction & Relationships: One component that relates to satisfaction is the ability of patients to access services and information easily. Through the techniques described in **Fig. 3.3**, Network 2 has identified key access mechanisms to facilitate the

KEY CUSTOMER SERVICE MECHANISMS

KEY ACCESS MECHANISMS	PURPOSE
Community Based Clinics, Primary & Specialty Care & Emergency Rooms	Provide easy and convenient access to health care services within the patient's local community. This is essential considering the large catchment area served by Network 2. Specialty care is also available to all patients at all Medical Centers.
Tel-Care Program	Provides 24/7 Nurse triage services via a 1-800 number easily accessed by patients
Veterans Service Centers	Provide "one stop shopping" & serve as a central point for assisting patients with questions regarding accessing VA healthcare, VA benefits, eligibility determination, billing questions, obtaining identification cards and general questions.
Patient Advocate Programs	Patient Advocates are highly visible and are a primary venue for patients/customers to obtain information, answers to questions and for reporting and resolving complaints.
Network 2 Web-site/Virtual Help Desk	Internet technology and email communication which provides information to patients, customers and stakeholders on health programs & benefits and provides a forum for patients to seek and obtain answers to questions. Available 24/7.
Greeter Program	Patients/customers in need of assistance or information have immediate access to 'Greeters' upon entry into Network 2 facilities. 'Greeters' are solution facilitators and good will diplomats.

Fig. 3.3

ability of patients to obtain health care, information or issue complaints. Customer service feedback from our listening posts is the leading mechanism for Network 2 to identify key requirements. The Customer Service Council reviews collected data, trends it, and aggregates results to make improvements in service delivery and communication. The Plan-Do-Study-Act model is used to resolve systems problems. **(Fig. 6.1)** Feedback obtained from patients identified the following contact expectations: prompt service, appropriate level of care, concern & courtesy shown by employees and completeness of explanations by staff. **Fig. 5.4** shows how we identify educational needs.

Customer service expectations are communicated through the inclusion of customer service standards in performance appraisal plans for all employees. In addition, customer service is a key element in the Goal Sharing Program. Leaders also communicate service expectations at Town Meetings, routine staff meetings and as part of the organization's Mission, Vision & Values statement.

3.2a(3) Complaint Management Process: The techniques described in **Fig. 3.4** outline Network 2's methods for processing complaints. Network leaders recognize and empower employees at the point of contact to resolve patient complaints. **(Fig. 3.2)** Front line staff receives specialized training **(Figs 5.5&5.6)** to enhance their skills in complaint resolution. Patient Advocates are available to provide information and assist in resolving complaints for all patients that are not resolved at the point of contact. Patient Advocates communicate with patients until satisfactory resolution of complaints is achieved. They document and track complaints, interventions and resolutions in a computerized database used for trending and analysis. The top areas of concern include information/ assistance, patient involvement in decisions, communications and timeliness of services. This information, along with data from quick cards, is reviewed by the Customer Service and Executive Leadership Councils.

Patients also have electronic options for reporting complaints through web-based quick card and Virtual Help Desk programs. Each help desk request is documented in an Access database to ensure follow up. The Network 2 website receives approximately 4000 hits per day. Quick Card complaints are acted upon immediately and communicated to the patient if contact information is provided.

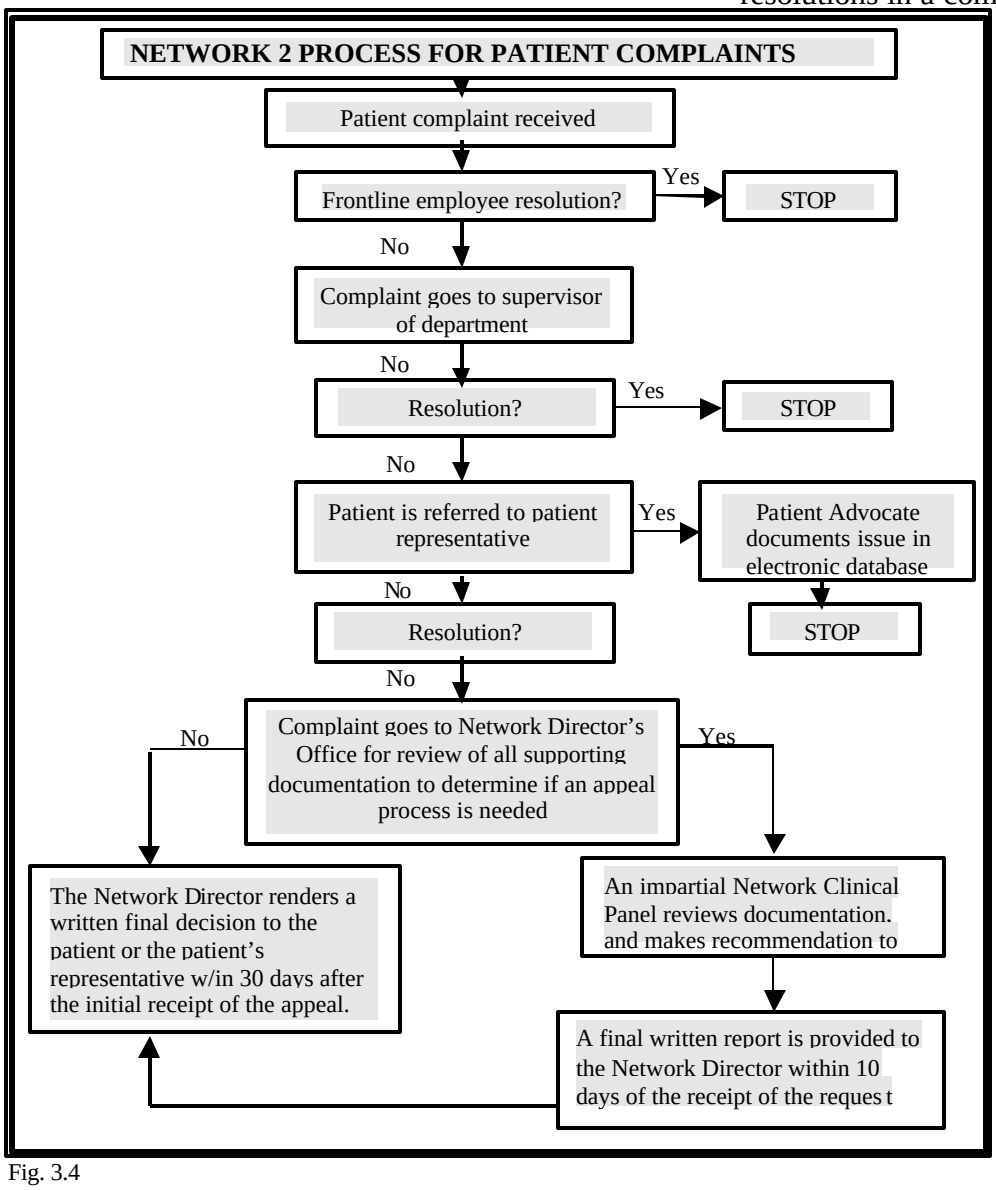


Fig. 3.4

MEASUREMENT OF CUSTOMER SERVICE

Measurement Method	Data Obtained	How Deployed
National Customer Satisfaction Survey	The National Customer Task Group used NCQA data to benchmark against industry leaders in customer service. Results of customer service dimensions deemed most important to patients is presented in **Fig 7.1K**.	Reviewed by CSC, ELC & TSPQ to develop action plans. Results listed on DSOs & Pulse Points
National Customer Service and Timeliness Standards	Network 2 is an active participant in a national VA project to reduce waits and delays in our outpatient clinics. The project is done in partnership with the Institute for Health Care Improvement (IHI). The continuous testing of changes and the measurement of improvements in access, capacity, demand, efficiency and patient satisfaction have been instrumental in improving timely access to outpatient care in Network 2. **(Fig 7.5J)**	Data reviewed by CSC, ELC, TSPQ and available on DSOs and Pulse Points
Patient Advocate Database –	Database houses information relative to patient contacts/interventions and serves as a primary resource for evaluating patient dissatisfaction	Data is trended & reported ELC, CSC for development of actions.
Quick Card Program	Provides a *quick* avenue for obtaining instant feedback from patients. Corrective actions are immediately taken and are communicated to patients. **(Fig 7.1F)**	Data reviewed by CSC, TSPQ, ELC
Internal Shopper Program	Initiative designed to focus on the expectations of our customers as seen through the eyes of a VA employee. The implementation of a Patient Travel Lounge was inspired by VISN 2's Internal Shopper Program.	Information is used to take immediate corrective action.

Fig. 3.5

3.2a(4) Relationship Building: Network 2 has implemented many programs to foster and build positive relationships with our patients. Programs are listed in **Fig. 3.5**. In addition, we have initiated the practice of assigning pagers to outpatients so they may move freely about medical centers and be contacted by pager when they can be seen. We also provide Bayer training for providers and CARE training for all employees in order to enrich customer service and communications **(Fig. 5.5)**. Other actions taken are described in **Fig. 3.6**.

Building Community Relationships

Marketing Activity	Examples
Fairs	Enrollment Fairs, Regional, County, NYS Health Fairs
Speakers Bureau	Professional staff presentations to scholls, community support groups, professional groups, colleagures, VSO, VFWs
Reports/Newsletters	Veterans Wellness Newsletter, '*Report to the Communicty*', Network 2 Comprehensicve Healthcare Brochure mailed to all patients.
Surveys, Contacts with Patients	Marketing survey targeted at non-users CBOC development 60 minutes/60 mile standard to top 5 specialties.
Web-Page/Virtual Help Desk	Provides comprehensive listing of programs and services offered within Network 2 and opportunities to seek answers to questions.
Referral Linkages	Department of Labor offering of VA Healthcare to veterans without healthcare insurance.

Fig. 3.6

Approaches used to ensure easy access and relationship building are constantly evaluated to keep current with customer requirements and organizational direction. Some changes include implementation of a questionnaire to ascertain why veterans have left VA healthcare and distribution of the *Annual Report to the Community.* Our Wellness Newsletter periodically surveys veterans to determine their desires for information/service. Information obtained is used in the planning process described in **Fig. 2.1** and in the design model described in **Cat. 6.1**.

Our Virtual Help Desk received a VA Scissors Award for making a significant difference in customer relations by enhancing communication with our patients.

3.2b(1) Customer Satisfaction: We utilize numerous methods to measure patient satisfaction or dissatisfaction, and to identify opportunities for improvement with measurable actions. Satisfied patients build repeat business and provide a valuable source for future referrals via word of mouth. Network 2 has been successful in improving satisfaction **(Figs. 7.1Q-Z),** increasing patient retention **(Fig. 7.2O)** and in patient growth. **(Fig. 7.2N)** Collecting, tracking and trending data from the programs described and taking action to continuously improve have contributed to improvements in these areas.

Patient satisfaction is also closely linked to health care outcomes. Network 2 uses surveys to improve the delivery of health care services by assessing patient expectations relative to health care outcomes. We have achieved best practice for

customer satisfaction in Access to Care, Specialty Care and Waiting Times. Delivery of preventive health care service and adherence to clinical guidelines is also a source for building loyalty and satisfaction with Network 2 services. **(Fig. 7.5A-P)**

Our customer service approach is based on improving access and quality by creating systems that identify needs from multiple sources and improving services. Feedback obtained from our various listening posts enables leaders and staff to understand service features that are important to patients. The collection of action-based information allows Network 2 to deploy prompt and effective solutions to patient complaints and needs as well as to enhance satisfaction and build patient and provider loyalty. Effective customer service ensures customer retention and positive referrals.

3.2b(2) Follow Up Communication: The Quick Card, Patient Advocate, Comping and Greeter programs provide more immediate and actionable service recovery feedback on recently delivered services. This information is quickly converted into action items by local staff and leadership to improve service and health care delivery. Patient Advocates communicate with patients regularly until a satisfactory resolution is achieved. Each Medical Center in Network 2 also performs telephone surveys within 48 hours of discharge from an inpatient stay. This survey evaluates the status of recently discharged patients and provides an opportunity for patients to get answers to questions or concerns. The patient is also given an opportunity to provide feedback on his/her hospitalization experience. This data is compiled on a quarterly basis for Network staff and leadership and is valuable in identifying areas for improvement. Feedback from this process resulted in development of several programs. For example, business cards were issued to housekeeping staff so patients could contact them for services, a Patient Envelope was issued to house patient education materials in a portable file, and a pilot program was implemented to use business cards on patient meal trays so patients can contact dietary departments.

3.2b(3) Satisfaction Comparisons to Competitors: An essential component of measuring customer satisfaction is an analysis of Network 2 performance relative to industry benchmarks and/or similar health care organizations. Network 2 is an active participant in a national VA project to measure waits and delays. Timeliness is tracked and readily compared to other networks. **(Fig. 7.4A-B)**

3.2b(4) Keeping Approaches Current: The Executive Leadership and Customer Service Councils are the key groups that evaluate how well the Network has learned from its patient experiences. The Customer Service Council recommends meaningful plans and actions based on patient experience feedback, strategic goals and tactical plans. They evaluate Network performance and explore VA and non-VA best practices. Through this process, we have adopted several "best practices" from local HMOs, which assisted in the development of the Veterans Service Center and the Patient Binder. Listening to our customers' feedback and understanding the nature and reasons for both positive and negative experiences assists the ELC and planners to develop strategic and operational actions. Analyses of measuring techniques are critical to becoming more responsive to our patients needs and in identifying new and creative ways to measure satisfaction. **(Fig. 3.5)**

In Fiscal Year 2000, the Network Customer Service Council received the Under Secretary for Health Innovations Award for their creativity and work to improve VA systems for our patients Initiatives for continued success are shown in **Fig. 3.7**

.Patient/Customer Service Initiatives For Continued Success

- Patient Admission Process Video
- Patient "Binder" for every Inpatient Room, Outpatient Clinic – Posted on VISN 2 Website
- Patient Education Envelope Given to Every Enrollee
- Semi-annual Customer Service Newsletter, *Exceeding The Expectation*
- Bayer (Patient Centered) Training for all Providers (Physicians, Nurse Practitioners, Physician's Assistants)
- Customer Service Training for Staff to assure Extraordinary Service
- Benchmarking Activities – Learning From "Best Of the Best
- "On-Demand" Bedside Video System, Which Includes a Patient Survey Component

Fig. 3.7

4.0 INFORMATION & ANALYSIS

4.1 Measurement &Analysis of Organizational Performance

4.1a(1) Data Integration: The Network 2 data system achieves comprehensive and appropriate levels of access to information that enhances decision-making for our senior leaders as well as front line staff. The Strategic Information Systems Council is responsible for ensuring an effective consolidation of our information systems, processes and resources under one "umbrella" **(Fig. 4.1).**

The Network-Wide Information System Managed by the Strategic Information Council	
FUNCTION	**SYSTEM**
• Reliability	• Hardware and data integrity
• Data System	• Data access and security
• Availability	• Data reporting and analysis
• Usability	• New technology
	• Systems enhancement

Fig. 4.1

This infrastructure facilitates an exchange of pertinent financial, operational and clinical information among our facilities and Care Lines, employing the combinations of point and click computer utilities, integrated computer systems and the VHA intranet.

Our Knowledge Management Office monitors data availability and data integrity. Data is gathered from a variety of sources, primarily government databases, and delivered to requesters. Comparative data is acquired using sources recommended by requesters.

Key performance measure results are disseminated in written, electronic and verbal forms, analyzed and used to achieve systems improvement, staff involvement and individual ownership of results.

4.1a(2) Measurement, Selection and Alignment: We select measures on the basis of their relevance and value in evaluating achievement of organizational goals and objectives. The selection of what measures are to be used, the collection methods and how often the dataset is reviewed is included in the development of the Network-wide set of performance measures that are linked to the key business drivers. Our leaders review this data monthly to assess their own and organizational performance, and identify opportunities for improvement. To improve overall organizational performance and patient outcomes, performance indicator results are incorporated into both our interactive strategic planning and our health care service design-redesign process that is based on the plan - do - study - act process improvement cycle (**Fig. 6.1**). In addition to guiding our strategic planning, selected indicators are valuable tools in evaluating daily operations **(Fig. 4.2)**.

Managers and supervisors responsible for job productivity align performance indicators with our Network's key business drivers, providing a systematic way to evaluate daily operations. This includes clinical and non-clinical operational issues. Administrative support performance measures are integrated into patient care operations in addition to being developed specifically to ensure productivity, e.g., reimbursements from third party health insurance providers.

The Goalsharing Program, where our employees are rewarded for the successful attainment of front-line quality improvement initiatives, is an integral part of monitoring how well strategic plans are put into operation. To assist the decision-making process, leaders and front-line staff are involved in

How We Use Indicators to Evaluate Daily Operations

Performance Measure & Critical Success Factors	Linkage Results	Relationship to Strategy (Critical Success Factors)	Examples of Relevance to Daily Operations
Number of Patients **Growth in Enrollment** **Market Penetration**	Fig. 7.2N Fig. 7.2P Fig. 7.2K-L	**PATIENT GROWTH**	Used to determine appropriate staffing levels, resource needs, demand for services, marketing fairs, Untapped markets, establishment of Community Based Outpatient Clinics
Cost Per Patient **Staffing Per Patient** **Acute Bed Days of Care**	Fig. 7.2A Fig. 7.2C Fig. 7.4F	**VALUE & EFFICIENCY**	Evaluation of standardization efforts, use of blanket purchase agreements/group purchase discounts, evaluation of staffing levels, analysis of length of stay & associated discharge processes
Patient Satisfaction **Quick Card Results**	Fig. 7.1Q-Z Fig 7.1AE-AH	**CUSTOMER SERVICE**	Evaluation of customer service, timeliness of services, systematic changes to daily operations to improve customer satisfaction, development of programs to enhance health care service delivery
Mental Health Follow up **Clinical Practice Guidelines**	Fig. 7.1A Fig. 7.1A-P	**QUALITY HEALTHCARE**	Standardized measures of quality are integrated into daily delivery of health care services via continuous provider education, enhanced documentation tools, and patient education

Fig. 4.2

goal development and informed of program outcomes. Our Goalsharing Program and a standardized set of measures integrate and align organizational and individual performance expectations with critical success factors (**Fig. 2.7)**.

Complete data is the key foundation in our performance measure analyses. **Fig. 4.3** illustrates how we select data criteria that ensure completeness. Network 2 equally weighs each of these factors when considering data.

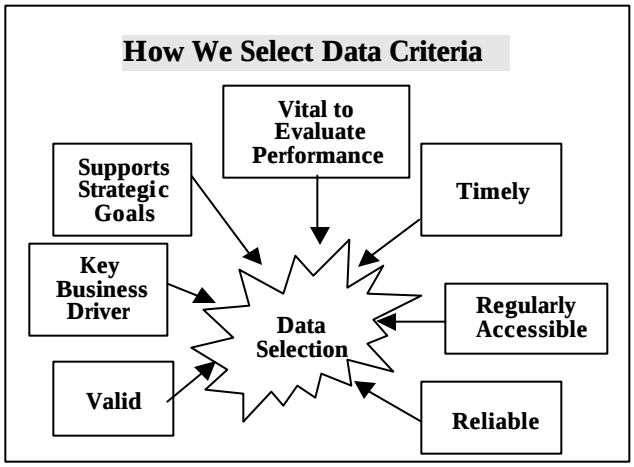


Fig. 4.3

4.1a(3) Ensuring Comparative Data: Network 2 uses comparative data to set stretch goals, evaluate performance and target areas for improvements. Comparative data and information is selected based on its potential for benchmarking, applicability to stretch goal formulation, level of compatibility with Network measures/data, potential benefit to patient care outcomes, and relevance to Network key business drivers and processes. Our success in using this technique is reflected in reduced cost per patient, increased patient growth and market penetration, improved customer satisfaction scores and enhanced quality of care. Stretch goals were established based on comparisons to best practice levels from multiple sources including other Veterans Integrated Service Networks, the National Committee for Quality Assurance, Healthy People 2010 and New York State HMOs. **(Fig. 2.8)** Projected goals are defined via the strategic planning process. **(Fig. 2.9)**

It is integrated into our culture that comparing Network 2 performance measure results against the best outcomes of other Veteran Healthcare Networks, nationally set performance targets, the Veterans Health Administration average and when possible, commercial industry standards, is effective in setting stretch goals and targeting improvements.

4.1a(4) Keeping Current with Health Care Needs: Performance requirements are derived from standards established by numerous national healthcare organizations including the National Committee for Quality Assurance, Joint Commission on Hospital Accreditation and Health Care Finance Administration, in addition to goals set by the VA. These requirements help us keep pace with the healthcare industry change such as the shift in patient care from the inpatient to the outpatient setting.

Network 2 updates data on key measures on a monthly or quarterly basis and compares performance with previous periods to assess current levels of achievement. Data is used to compare relative success of our healthcare network against the best Veterans Healthcare Networks in the Veterans Health Administration and comparable organizations in the private sector. Our databases are also updated monthly with nationwide data to ensure up-to-date, moving comparisons over time.

To respond to changing data needs, there is a formal request process to access the considerable resources of the Knowledge Management Office (KMO). Among those who are served by the KMO are staff, suppliers and partners. Requests are reviewed to see if existing reports will meet the requester's needs. If new development is required an assessment is done to determine data sources. Requests requiring long or difficult development efforts are referred to the Chief Operating Officer Council for guidance in setting priorities.

The KMO has implemented a survey process to obtain feedback from its customers to ensure that the data is relevant and useful. Report formats and dataset characteristics are modified as needed. The survey helps to ensure that report formats are optimized for accurate evaluation of the performance of our key clinical, financial and operational processes and outcomes.

Programs like the Quick Card and Internal Shopper were created in response to the lag time associated with national customer service data. These programs provide more immediate feedback with quick cycle recovery to improve customer service.

4.1.b Performance Analysis & Planning

4.1b(1) Analyses Used to Support Senior Leaders & Strategic Planning: There are various methods used to analyze data including trending analysis, projections, comparisons, force-field analysis, pareto analysis, root cause analysis, and cause and effect relationships. The results are reviewed and acted upon by our senior leaders at the Executive Leadership Council, Local (Medical Center) Leadership Councils and key Network Councils.

The analysis of data assists our leaders and managers in decision-making, resource allocations, operations improvement, health care outcomes improvement and in strategic planning. Our use of comparative data to similar organizations is a key element in defining stretch goals and driving innovations and improvements in our Network. Data analysis is also done in support of the strategic planning process to anticipate future health care needs and fuel our plan – do – study – act process design/re-design **(Fig. 6.1)**.

For example, an analysis of customer service results in prior years identified poor performance and an opportunity for improvement. In response, we took a series of planned steps to improve our customer service performance. These steps included the establishment of the Customer Service Council, focused training seminars, development of the Quick Card Patient Feedback and Greeter Programs and adoption of customer service performance standards for all staff. The improvement in customer satisfaction results demonstrates that the actions we took have effectively turned patient dissatisfaction into patient delight.

4.1b(2) Communicating Results: Network 2 collects and aggregates data and displays it for analysis in Pulse Points and in Decision Support Objects (DSOs). We publish our performance measure results monthly in the Pulse Points, and other operational and financial data in the DSOs, which our senior leaders use to support daily operations. The Pulse Points report contains a summary and analytical comments on organizational performance. The DSO program is the Veterans Health Administration's most comprehensive Network-wide system for maintaining current performance, fiscal and operational data; it has been showcased on a national level as a Veterans Administration best practice.

The DSO program is installed on senior leaders' and data managers' computers, providing results in a point and click format for key categories and measures. Pulse Points, Network 2 web site and facility town hall meetings provide data on major indicators of organizational performance to all our employees at all levels of the organization. This enables our employees to assess overall performance relative to strategic objectives and critical success factors **(Fig. 4.4)**.

On-Demand Access to Data in Network 2

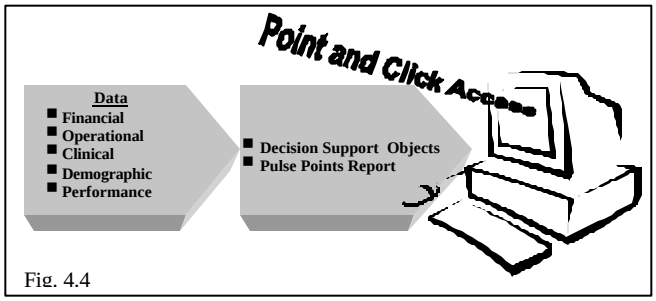


Fig. 4.4

4.1b(3) Aligning Analysis with Performance: Our continuous data retrieval and analysis is aimed at assessing health care processes to facilitate achievement of performance targets for key business drivers. Review of key data by leaders, supervisors, unit employees and Network Councils contribute to organizational learning and an understanding of organizational performance. This facilitates the development of needed action plans to improve health care and processes that support health care delivery on a daily basis.

How Data Analyses is Used in Meeting Our Critical Success Factors

Critical Success Factors	Types of Analyses
Patient Growth	• Market Penetration Changes • Increase in Number of Patients Treated • Outpatient Visit trends
Customer Service	• Trends in Waits & Delays for Appointments • National VA Patient Satisfaction Comparisons • Reported Complaint trends
Health Care Value	• Cost per Patient trends • Staff Turnover Rates • Resource Allocation Analysis
Quality Healthcare	• Performance of Prevention Care and Chronic Disease Screens and Implementing Follow-up Treatment • Education and Training trends • Outcome monitors

Fig. 4.5

Figs. 4.5& 4.6 give examples of Network 2 analyses and how we used them in our daily operations. The ongoing analysis of data on waits and delays in our outpatient clinics and the

How We Support Our Daily Operations with Effective Communication of Data

Key Product or Process	How data used to support Daily Operations
Diagnosing, Treating & Preventing Diseases	Information on Clinical Practice Guidelines, CDI/PI scores and health care outcomes are used to adjust the delivery of care performed on a daily basis, i.e., referral of outpatients to our Smoking Cessation Program.
Customer Service	Trends in Waits & Delays, Satisfaction Results, reported complaints are used to take corrective action to daily operations, i.e., Clinic timeliness, Quick Cards
Enrolling Patients	Market Penetration Data, increase in patients treated are used to target recruitment and health fairs and for CBOC development

Fig. 4.6

continuous testing of action plans in the areas of access, capacity, demand, efficiency and patient satisfaction were effectively applied to dramatically improve timely access to outpatient care. The process owners (staff) identified systematic changes to daily operations, such as scheduling processes, and innovative solutions to clinic management to achieve overall improvements. Our leaders at each medical center also meet each morning to review pertinent daily information, such as hospital admissions and discharges, sentinel events, and service and patient care issues. This facilitates timely course corrections to ensure optimal daily performance.

4.2 Information Management

4.2a(1) Information Availability and Accessibility: The Strategic Information Systems Council is responsible for continuous coordination and guidance related to strategic information initiatives, priorities and actions to the Executive Leadership Council. The nature of this guidance consists of recommendations that effect access, goals, expansion, integration, quality, validity, standardization, new ventures, and any other issues that impact the Network Business Plan.

The Knowledge Management Office provides databases, applications, reports and data architectures to meet requests from staff, suppliers, partners, patients and other stakeholders. A web-based request form facilitates access through the intranet. Our Knowledge Management Office resources understand the business purposes of the data they create, and actively solicit customer needs for data and data quality requirements.

Our Network 2 Intranet and Internet websites have been in existence for nearly four years and have become a trusted source of information for employees, customers, markets, and stakeholders. The Intranet provides an internal system for distributing information to employees, other Networks, VHA Headquarters, and others. Information about the public web site is marketed through our contacts with the veteran's service organizations and at events involving the Network's Public Affairs section. Website demonstrations for partners and stakeholders promote awareness and usage of this resource. As an example, the VISN 2 Web Team presented an educational session at this year's VA Voluntary Service Conference, educating participants on how to access the Internet. This collaboration fosters new relationships with key stakeholders and was supplemented with ongoing Basic Internet Classes for Volunteers at Medical Centers across the Network. The Web Development Team offers presentations in a variety of other forums to facilitate access to this knowledge rich resource. Partnerships with organizations such as the New York State Veterans Coalition offer rich opportunities to share information.

Patient information is maintained in the Computerized Patient Record System, and made accessible to our providers on desktops with point - and - click utilities. Patient and staff educational videos are made available through the On-Demand delivery system. This uses cutting edge technology and received the **2001 Under Secretary for Health's Award for Innovation**. Healthcare information is available through kiosks and at patient education resources centers located throughout our Network.

To accommodate patient information needs where contact with an individual is needed we offer the TelCARE program where patients can access information 24 hours a day 7 days a week from a courteous Network 2 representative. Patients also have the option to contact the facility Veteran Service Center or Patient Advocate.

4.2a(2) Data Integrity & Security: We have assigned Information Security and Compliance Officers to maintain control of electronic system

access and system integrity, reliability and optimization of equipment. The Strategic Information Council ensures that hardware and software meet end users' needs, are identified and implemented in an effective manner and are maintained to ensure reliability and security of systems **(Fig. 4.1).** Leaders and staff incorporate statistically significant sample sizes into the performance review process to ensure valid results are obtained.

Formalizing the process of data generation and dissemination through the Network 2 Knowledge Management Office ensures appropriate use and confidentiality of information.

Our Network-wide Information Security Program protects all Information Systems and telecommunications resources from unauthorized access, disclosure, modification, destruction, or misuse, and complies with Federal security laws and regulations. All users of our information systems complete information security training and we ensure that patient information is maintained and used appropriately by monitorinG **(Fig. 4.7)**.

INFORMATION SECURITY SYSTEM

Monitor Description	Frequency	Purpose
Sensitive record access	Daily	Prevent unauthorized access
Internet usage	Daily	Ensure proper use of resources
User access	Monthly or quarterly	Detect and prevent improper access
Incident response	As needed	Prevent negative impact of system resources

Fig. 4.7

Issues and recommendations are forwarded to the appropriate parties responsible for action. Our Electronic Medical Record Contingency plan ensures the continuity patient care and maintains the integrity of patients' medical records during periods of scheduled or unscheduled computer system downtime.

4.2a(3) Keeping Data Availability Mechanism Current: Under the aegis of the Knowledge Management Office, we have instituted a data quality program managed by the Data Quality Council to look at information chains that are critical to the organization, such as patient addresses. The Data Quality Council meets monthly and is comprised of data managers and members of the Strategic Information Systems Council and Knowledge Management Office. In response to changing database requirements, teams are formed with specific tasks to evaluate existing processes that impact on the data input and usability. To ensure coordination Network-wide, recommendations are forwarded through the Transforming Systems Performance & Quality Council whenever there is significant impact on daily operational activities. The Executive Leadership Committee then act upon the recommendations from the Transforming Systems, Performance & Quality Council.

By linking our information technology resources through the Strategic Information Council, we have partnered our systems hardware and software expertise with our healthcare system leadership, as we continually seek new technologies and data

Information and Analysis Strategies for Continued Success

- **Fully Implement an Electronic Medical Record and Improve Electronic Tools Available to Providers**
- **Reengineer and Automating Administrative Processes**
- **Provide Effective Knowledge Management Tools and Data to Clinical and Administrative Staff**
- **Provide Patients and Staff Tools that Provide Alternative Methods to Easily Access Services**
- **Provide Employees and Patients on-line Educational Tools and Opportunities**
- **Provide Increased Information Systems Responsiveness to Provider and Administrative Staff Needs**

Fig. 4.8

The Network 2 website relies on an analysis of current usage patterns to provide important information for assessing our user's interests and needs. Server log analysis software is currently being used to perform this function. Usability testing and feedback from both veterans and employees is integrated into site improvements in design, content, and function.

4.2b(1) Hardware and Software Reliability: The Information Systems system managers routinely monitor the computer systems and correct problems (**Fig. 4.9**).

HARDWARE & SOFTWARE MONITORING

Monitor Description	Frequency	Purpose
Disk space (hardware)	Daily	Prevent system shut down
Database global integrity	Weekly	Detect and correct database problems
Database global efficiency (growth)	Monthly	Trend long term storage issues
Resource Device - CPRS background task	Hourly 7am-5pm M-F	Monitor and resolve problems with patient information access
Monitor Cluster - CPU utilization	Twice a day	Detect and remove performance bottlenecks
# active users	Twice a day	Access activity/ performance relationships

Fig. 4.9

Systems issues such as performance, storage and data integrity are communicated from the system managers to the Strategic Information Council via the Knowledge Management Office. Knowledge Management Office ensures that data maintained in Network 2 databases is accurate and complete.

Our Information Systems organization acquires and maintains all hardware and software, ensuring that it is compatible with our multi-platform network configurations. They ensure the integrity of communication pathways, maintain a registry of all equipment and recommend new technologies.

4.2b(2) Keeping Hardware and Software Systems Current: The Strategic Information Systems Council (SIC) is responsible to the Executive Leadership Council for continuous coordination and guidance related to strategic information initiatives, priorities and actions. Their guidance includes recommendations that affect access, goals, expansion, integration, quality, validity, standardization, new ventures, and any other issues that impact the Network strategic plan.

Information Systems conducts an annual survey to ensure that the needs of the users are being met and provides demonstrations and pilot projects to test new hardware and software, giving end users the opportunity to test and provide input.

Our Information Systems organization constantly monitors feedback reports and new equipment requests from data users and tests new releases of software. They proactively seek news and updates from manufacturers' web sites, closely following the information technology industry for the latest trends and products to enhance our systems, attend health information management system conferences and conventions, and follow industry news groups for both hardware and information systems.

Within the Information Systems section there is an encouragement of innovation that prompts new technology reviews. The incorporation of new technologies follows the plan – do – study – act model **(Fig. 6.1)**. In addition, they actively participate on councils in our Network to support and share new ideas and concepts. The partnership between our Information Systems resources and our Network Imaging Council is driving our Network strategic initiative to further enhance the electronic medical record to include diagnostic images. Among others, the success of our teleconferencing / telemedicine technology deployment is a testament to our hardware and software quality program.

Our Network 2 web site Virtual Help Desk program has served more than 1300 requests for assistance since January 1998 and demonstrates a powerful use of technology to provide innovative service using electronic interactions. This program exemplifies the successful integration of technology with existing business processes as we tap the commitment and expertise of our patient advocates and other subject matter experts to connect veterans with VA professionals in a virtual environment. The response to this program continues to be a positive outflow of satisfied veterans. The Network 2 Virtual Help Desk is noted as a VA Best Practice and is being explored as a model for all VA Networks to ensure responsive customer service in a continuum of care. For the past several years, the Virtual Help Desk and web-based Quick Card have been rich tools for user need assessment. Submissions continue to be monitored daily and provide unique insight into the needs and desires of our patients, their families, and caregivers. Prioritization of web content areas is often a direct result of perceived needs.

5.0 STAFF FOCUS

5.1 Work Systems: Our organization seeks exceptional performance by giving staff an opportunity to participate in planning and redesign of work processes, and by encouraging self-directed actions to achieve superior results.

5.1a(1)Organizing & Managing Work: Self-directed teams are empowered to redesign work systems at both the Network and local levels, in order to achieve measurable improvements in quality and veteran satisfaction. Staff involvement at the front line level is achieved through the establishment of process improvement teams, focus groups and task forces. Staff have produced excellence on behalf of our patients through the following approach **(Fig 5.1).**

HOW WE ENABLE STAFF & THE ORGANIZATION TO ACHIEVE HIGH PERFORMANCE

- **Set Performance Expectations At The Highest Level Of The Health Care Industry**
- **Empower All Staff Through Self-directed Actions**
- **Develop Shared Accountability To Transform The Organization**
- **Recognize And Reward All Staff**

Work is managed through interdisciplinary collaboration with self-directed teams given broad direction or charters, enabling them to be innovative and creative in their analysis and recommendations for work redesign. **Fig. 5.2** illustrates how our teams/councils have helped ensure continuing work design and process improvement in seeking organizational excellence:

Crucial to our staff's ability to transform the organization is the availability of advanced data and information systems, permitting timely retrieval of patient and business support information and improved decision making. **(Figs 4.4, 4.6)**. Information and data systems are made available to staff at the front line to support daily operations, as well as to senior leaders for long range planning and organizational assessment. Multiple approaches are used to share information including daily videoconferences, joining all sites across Upstate New York, joint Care Line meetings, all-employee computer messages, and use of our Award-winning website. Network 2 staff-developed data systems, Decision Support Objects (DSOs) and Pulse Points, are used by staff at all levels to access important clinical, and

Fig. 5.1

How Our Teams and Councils Design Work Systems

Critical Success Factors	Mechanism	Project Example	Process	Outcome/Impact
Quality	GHQ Team (temp, formal)	Provide mental health for primary care patients, using General Health Questionnaire	Diagnosis of Diseases & Conditions	All veterans seen in primary care settings are screened annually using the GHQ.
Quality	BCMA Implementation Team (temp, formal)	Facilitate implementation of Bar Code Medicine Admin. across Network	Treatment of Diseases and Conditions	Bar Code Medicine Administration was fully implemented across the Network during 2000
Quality	Diabetes Project Team (short term, formal)	Design a disease management program for diabetes meeting NCQA requirements	Disease Prevention, Health Promotion and Health Status	Pilot study at Rochester Outpatient Clinic completed in 2000; clinical practices implemented at other sites
Satisfaction	Service Ctr. Design Team (s/t informal)	Design an integrated customer service system meeting NCQA requirements	Enrolling Patients	Establishment of Veteran Service Centers at all medical centers
Quality, Satisfaction	Electronic Medical Records Committee (	Migrate to a fully electronic medical record	Management of Information	All orders are electronically entered into the medical record; progress notes are electronically entered
Quality	Network Education Council (long-term, formal)	Improve the process for identifying and meeting education needs in the care lines	Education and Development of Staff	NEC distributed education funds to each care line and assigned education coaches to help define education plans
Value	Capital Asset Team (long-term, formal)	Prioritize capital improvement needs	Environment and Facilities Mgmt.	The first Network-wide capital assets plan based on care line input in 2000
Value	Fiscal Reengineering Task Group (temporary, informal)	Reengineer Network 2 Fiscal Service to better meet the needs of the care lines	Financial Planning	Fiscal Services reengineered, fiscal coaches established for Care Lines; accounting and auditing consolidated
Growth	Network Marketing Team	Collaborated with NYS DVA -identify veterans on Medicare, & contact those not enrolled in the VA	Enrolling Patients	All veterans identified have been contacted to inform them of their eligibility for VA benefits

Fig. 5.2

business support information and improve decision making **(Figs 4.2, 4.4).** Sharing of process improvements to sustain excellence is shown in **Fig 5.3**.

Coordinated Sharing of Process Improvements Through the Transforming Systems Performance and Quality Council

How	Who	What	Why
Utilization Summit	Interdisciplinary teams share innovations	Network 2 achieves lower drug costs **(Fig. 7.2D)**	Value
Education Summit	Education liaisons and care line representatives share practices and needs	Network 2 crafted a strategic education plan	Quality
Institute for Health Care Improvement Collaborative	Cross-care line teams share successes and noble failures	Network 2 improved clinic wait times **(Fig 7.4A & B)**	Growth

Fig. 5.3

5.1(a)2 Staff Motivation: Staff are motivated by giving them an opportunity to plan and design their work in an environment which encourages innovation and rewards them for their efforts. Goal sharing and the performance award system allocate greater award allotments each year to recognize staff for contributing to the organization's successes **(Figs 7.3D&F).** Staff are also encouraged and developed to their fullest potential through continuing education and training, including the High Performance Development Model, a conceptual model for creating a learning organization focused on employee development **(Fig 7.3I)**. Staff development is also achieved through mentoring and upward mobility programs, as well as through Web-based career planning tools with listings of Network employment opportunities.

5.1.a(3) Performance Management and Recognition: We reward our employees for their contributions to the successful achievement of our strategic goals, which are linked to our critical success factors. The Goalsharing Program, developed by Network 2 staff, employs a team concept with work unit teams setting goals that are aligned with the Network Strategic Plan. Goal Sharing won both the 2000 OPM Pillar award and the 2001 VHA Human Resources Management Innovations Award from the Undersecretary for Health **(Figs 2.8,7.3E).** Our labor/management team used employee and management feedback to further refine and enhance the Goalsharing Program in its second and third years. As a result, our teams developed goals that were more meaningful to smaller, natural work groups and further reinforced the link to our critical success factors.

Network 2 also maintains an employee recognition and award program to celebrate and recognize exceptional efforts in support of our mission. Individuals and teams are eligible for awards and any employee can make an award nomination **(Fig 7.3F).** Joint labor management teams participate in the nomination process to ensure fairness.

5.1a(4) Succession Planning: As the percentage of retirement eligible employees increases, plans are in place to identify and develop staff in accordance with the projected needs of our organization. Leadership development programs, continuing education, coaching and mentoring and upward mobility programs are all utilized to assure that the skill sets and leadership abilities are aligned with future organizational needs. The High Performance Development Model (HPDM), is employed to create a learning organization focused on employee development. Our HPDM Steering Committee, which includes membership of our union partners, is committed to assuring the professional growth of our staff in acordance with changing health care needs. Facilitated learning modules that include tapes of the core competencies are available through our award-winning, On-Demand video training system and at local facility education offices. In 2001, Network 2 introduced a leadership development program based on the HPDM. In its initial session ten employees from across the Network participated in this year-long mentoring initiative.

Our Employee Incentive Scholarship Program helps us develop quality healthcare staff in occupations for which recruitment and retention is difficult, including pharmacists, licensed practical nurses and physical therapists. Network 2 has implemented five MBA Programs in fiscal year 2001. All employees are given the opportunity for academic support.

5.1a(5) Employee Characteristics & Skills: Supervisors conduct job analyses to determine job-specific competencies required for each position. Our supervisors use Performance Based Interviewing, a selection tool that carefully defines needed skills and asks for examples of these skills in the interviewee's work experience. Our practitioners are credentialed through a systematic process of screening and evaluating qualifications and granted privileges based on verification of clinical competence. Physician retention is enhanced through academic affiliations, research opportunities and professional association. In response to projected nursing shortages, a nurse recruitment and retention work group was established, producing site-specific evaluations and action plans.

Through an extensive system of affiliations with colleges and universities we provide training for students in health related careers including pharmacists, therapists, psychologists, licensed practical nurses and administrators. Affiliations with university medical schools provide training for numerous medical and dental residents and assist in recruiting for hard to fill positions. Network 2 currently has on staff 245 residents from these schools. Students and residents involved in these programs come from diverse backgrounds.

5.2 Education, Training & Development
5.2.a.(1,2&3) Training and Education Design: The Network Education Council (NEC) provides multidisciplinary oversight for Network education programs and consists of representatives of care lines and key organizational entities, including Human Resources and union partners. Annually, our leaders conduct training needs assessments and submit the results to the NEC. To ensure that programs are aligned with the needs of the organization, the NEC evaluates the annual needs assessment from each care line, provides budgetary support and recommends distribution of education funds on a Network-wide basis. Plans are aligned with Network strategic goals and critical success factors. **Fig. 5.4** illustrates how we identify and manage long and short-term education needs for licensure, re-credentialing, development and career progression requirements.

Implemented in 2001, our Network 2 Academic Support Program set aside education funds specifically dedicated to support employees seeking college-level degrees in areas related to their position. Summer student training programs serve as potential sources for recruitment in future years by including students from historically black and Hispanic colleges and universities.

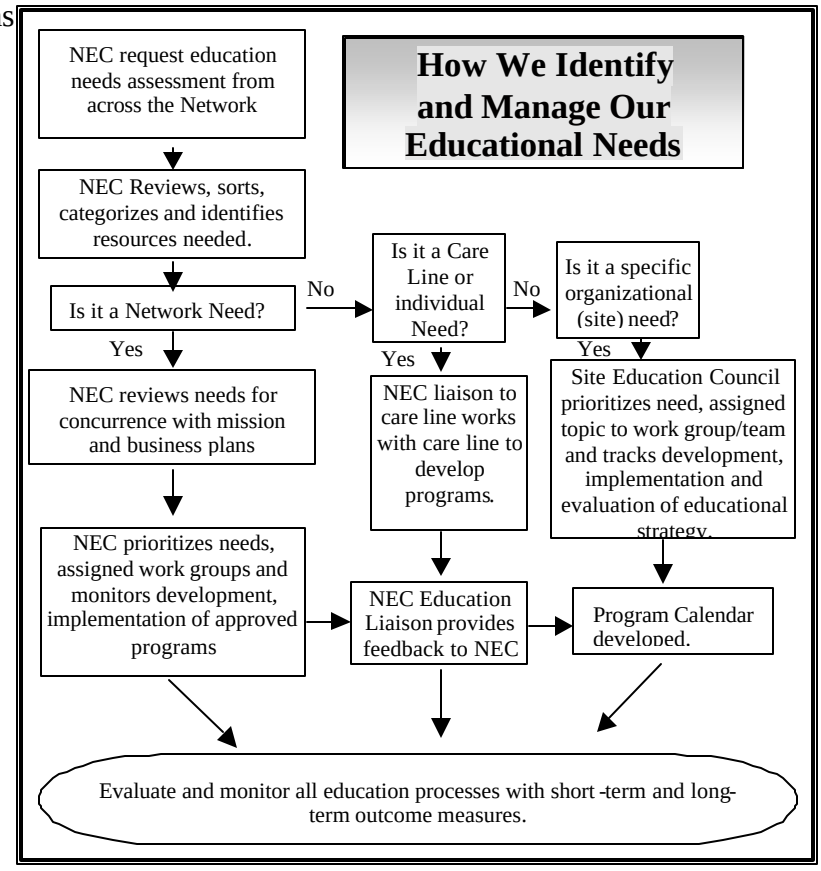


Fig. 5.4

The Network Cardio Pulmonary Resuscitation / Advanced Cardiac Life Support (CPR/ACLS) Training Center provides certification training for all interested employees. We employ an Individual Development Plan (IDP) to identify learning needs, as well as evaluate the effectiveness of training received. This cyclical process requires the employee and supervisor to collaboratively identify knowledge, skills and abilities that are needed to be successful; an IDP is reviewed and updated yearly or as needed. **Fig. 5.5** illustrates the alignment of Network 2 education/training initiatives with the Critical Success Factor, Veteran Satisfaction. The success

Training Initiatives to Improve Veteran Satisfaction

Education / Training Initiative	Description	Target Group
Time Management	Improve organizational skills for better time management	All employees
Keeping the Skills Alive	Strengthen the skills of customer service trainers	Customer service trainers at each medical center
Bayer Training	Enrich customer service and communications during patient encounters	Providers
CARE Training	Better understand contact requirements and enhance communications skills	Front line staff

Fig. 5.5

of the training is reflected in the improved customer satisfaction scores from 1997 through 2000 **(Figs 7.1Q-Z)**. The Network Human Resources Council redesigned the New Employee Orientation Program in 2001 to convey Network values and to familiarize our new employees with Network goals, work systems and processes. Annually we provide training on universal topics such as infection control, fire safety, computer security, ethical conduct, sexual harassment in the workplace, Equal Employment Opportunity, diversity and disaster preparedness. This training is provided through a variety of methods such as computer-assisted training, readings with post test, and classroom instruction in order to provide employees with several options for completion.

Employee orientation and training is entered and tracked in a Network-wide access database called TEMPO to ensure training requirements are credited and mandatory training is met. In 2001, 95% of our employees received at least 40 hours of continuing education **(Fig 7.3G).**

5.2a(4) Training, Education and Evaluation:
The Network 2 Virtual Learning Academy provides an educational system able to meet the demands of a complex organization and support innovative practices. We are committed to investing in the development and education of a highly qualified workforce. Six learning paths have been identified:

1. Clinical / Non-clinical Practice
2. Business Practice
3. Informatics / Technology
4. Leadership / Organizational Development
5. Patient / Family Education
6. Academic Affiliations

Selected methods used to offer education and training to employees at all levels are illustrated in **Fig 5.6**. A successful link of training and technology is our On-Demand Instant Healthline video-training program, which received the 2001 VHA Under Secretary for Health's Award for Innovation. We conduct post-training evaluations to determine participant satisfaction , applicability to the job and how training can be improved.

Training Methods

Key Process / Support Process	Training	How Delivered
Enrolling Patients	Customer Service	Lecture, coaching/mentoring, learning maps, worksite learning initiatives
Diagnosing Patients	Diagnostic equipment (e.g., MRI)	Purchased training from original equipment manufacturer
Treating Patients	Clinical treatment procedures	Live lecture, developmental assignments, training through professional organizations, satellite programs
Health Promotion	Smoking Cessation	Purchased training, VISN 2 trainers, On-Demand
Management of Information	Computer Literacy	Computer-based, self-learning, developmental assignments, worksite learning initiatives, in-house training program
Education and Development	High Performance Development Model (Figure 7.3I)	Web-based, live lecture, learning maps, coaching and mentoring, staff meetings, videotapes, college courses
Environment and Facilities Management	Safety	In-house training, training through professional organizations, self learning, satellite programs
Financial Planning	Funding sources	Live lecture, staff meetings, learning maps

Fig. 5.6

5.2a(5) Reinforcing Knowledge and Skills:
Skill sets are identified in position descriptions. Competencies are interfaced and evaluated within individual development plans to emphasize key skills. Knowledge and skills are then reinforced through required training, competency reviews and annual performance evaluations. Attendance at external conferences and classes is approved based on linkage to critical success factors, the educational plan and our organizational needs.

Training for our health care providers includes enhancing their discipline knowledge and skills, helping them to adjust to changes in health care delivery and delivery environments, and developing

and utilizing clinical guidelines. Attendances at internal professional forums, such as grand rounds, are opportunities for case presentation and learning for our clinical staff.

5.3 Staff Well-Being and Satisfaction

5.3.a Work Environment: A Network-wide Safety and Health Program ensures a safe and healthful environment for our patients, visitors and employees, while effectively managing the costs of accidents and hazard prevention and complying with the Occupational Safety and Health Administration (OSHA) regulations. The significant reduction in lost times claims rate from 1996 to 2000 attests to the effectiveness of our occupational health and safety training programs. **(Fig 7.3L)** Local environment of care committee member include safety staff, care line representatives, employee health, and union partners who identify program priorities and high risk areas, and plan remedial actions including safety educational programs. Employee union representatives are considered crucial to the safety process, and are given authorized time away from their job duties to participate in Network safety and health activities.

Our safety staff conducts ergonomic assessments of employee work areas upon request to determine what adjustments, if any, are necessary to ensure an ergonomic work site. Annual physical examinations and/or screening tests are offered to nurses. All employees are periodically tested for TB, and are offered annual flu shots. Many facilities have fitness centers available for employees to improve overall well being. We also offer the QuitSmart smoking cessation program for employees, free of charge, as well as stress management and time management courses. The Safety and Health Program has established an informative web page providing information for staff, visitors and patients.

5.3b(1&2) Staff Support and Satisfaction: Town and staff meetings, website surveys and the direct participation of labor representatives on the Executive and Local Leadership Councils gives us an excellent opportunity to understand and act on the concerns and needs that affect our staff. In addition, our Partnership Council fosters and maintains a cooperative, constructive labor-management relationship, winning the 2001 Labor-Management Partnership Award for cooperation. We place a special emphasis on employee diversity, bringing cultural events from the community into the medical centers. Each medical center also has special emphasis programs for minorities, women, and people with disabilities.

5.3b(3) Assessment of Staff Well-Being: Network 2 solicits feedback in various forms from our employees including a–web-base Employee Collaboration Tool, through which overall satisfaction is assessed with regard to key organizational components (**Fig. 7.3A&B**) In 2001 we conducted a Network-wide employee survey designed to identify strengths and opportunities for improvement. Areas our employees identified as strong points upon which to build include gaining more staff input during organizational change, and more effectively dealing with negative employees.

5.3b(4) Assessment Findings in Performance Results: Assessment of employee satisfaction is also done through review of key measures, such as turnover rates **(Fig 7.3J,Fig 7.3K)**. The Human Resources Council gathers and analyzes data and publishes a quarterly report to care line managers on turnover, grievances and unfair labor practice charges. In 2002, an Employee Quick Card feedback process will be implemented Network-wide proposed by staff and based on the successful patient Quick Card.

To foster an environment that is supportive of the needs of our employees, Network 2 Leadership utilizes various means to obtain employee participation and feedback. Initiatives we have implemented include:

- Web-based and traditional (paper) employee satisfaction surveys
- Web-based feedback to the Executive Leadership Council
- Web-based input into strategic planning
- Alternate Dispute Resolution (ADR) to more quickly resolve differences between employees without resorting to a formal grievance process.
- Union Partnership Council where labor and management work collaboratively to improve issues which effect employees.

6.0 PROCESS MANAGEMENT

6.1a Health Care Service Design Processes: Network 2 requires key processes that perform reliably and produce high levels of performance. The management of processes requires design/redesign, evaluation and continuous improvement. Network 2's approach to process management using the Plan-Do-Study-Act methodology is illustrated in **Fig. 6.1.**

6.1a(1) Design Process: All key healthcare, delivery and support, and supplier processes come under the scope of this design. The process begins with process owners acquiring customer/stakeholder needs designing the steps to meet those needs. As Network mission, patient population, VHA policy and accreditation requirements change, impact on the process is reevaluated and appropriate changes are made. **(Fig. 6.1)**

6.1a(2) Healthcare Service Decision Making: The decision to launch new or modified health care services is subject to evaluation and approval of our Executive Leadership Council through the strategic planning process as illustrated in **Figs. 1.6, 2.2, and 2.5.** Issues considered include market data, user demographics, economic and fiscal factors, mission changes and regulatory requirements.

6.1a(3) Incorporating Changing Requirements: Once the decision for health care delivery process improvement has been made, the Plan-Do-Study-Act method is used to design, deploy and evaluate the process. In the planning and design phase, select process stakeholders identify key internal and external expectations of patients, higher performance and operational reliability. These influences are integrated into a set of design specifications and performance measures ("Study"). The process is designed and deployed for testing, in alignment with these specifications ("Do").

6.1a(4) New Technology in Healthcare Services: To standardize our process for new technology, Network 2 developed the "Assessments of New and Existing Medical Technology" Policy **(Fig. 6.2)**

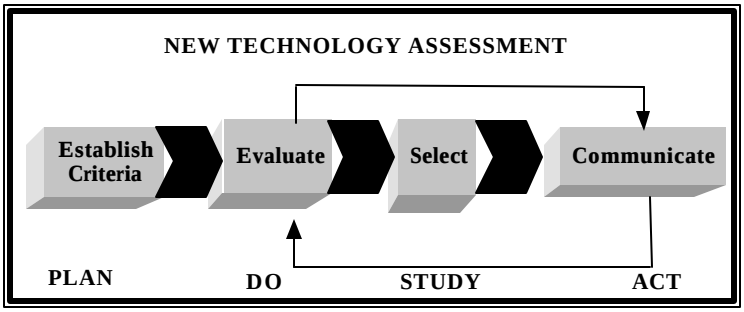


Fig 6.2

It employs such factors as applicability to our patient population, published scientific evidence related to clinical trials, regulatory agency

DESIGN PROCESS

PLAN	***Step 1 ~ Understanding the existing process.*** Evaluation of data, interviewing staff involved in the process, outlining the steps, and gaining consensus that there is potential for improvement. ***Step 2 ~ Identify customers and gather input concerning their desires related to the process.*** Information is gathered from patients and other customers. ***Step 3 ~ Translate customer desires into actual needs to include in the process design.*** Information gathered in Step 2 is interpreted in context of the healthcare system including financial, political, regulatory/accreditation requirements and overall population needs. ***Step 4 ~ Design an operational plan.*** Define a project plan, including steps, timelines, and the resources needed. This serves as a roadmap for completion and a history of the project completion.
DO	***Step 5 ~ Implement and pilot operational plan.*** ***Step 6 - Complete pilot studies (when indicated) for VISN wide projects.*** Designate facility or some other organizational entity to complete initial testing of a new process before exporting to a broader group. Evaluate pilot project data and make modifications. ***Step 7 ~ Complete implementation of the new or redesigned process.*** After testing in Step 5 is completed, this is the implementation phase for expanding the new process.
STUDY	***Step 8 ~ Establish quality, cost, and outcome measures to determine program success.*** Objective measures for baseline and post-implementation phases are selected when new healthcare processes are chartered. Measures may include meeting regulatory/accreditation requirements. ***Step 9 – Transfer lessons learned to other programs or areas.***
ACT	***Step 10 ~ Complete regular evaluations and recommend subsequent actions when necessary to continue to improve the process.*** Follow-up on regular basis by the process owner to ensure that the gains are maintained and unfinished actions completed

Fig. 6.1

6.1a(5) Quality and Cycle Time: Design quality, cycle time, cost control, new design technology, and other efficiency-effectiveness factors are addressed during the "Do" and "Study" phases of the design and improvement process **(Fig. 6.1).** Lessons learned are acquired at the end of the "Study" step, and the transfer of learning from projects is incorporated into the redesign of the same process, or during the "Plan" step (review of requirements) of a design or redesign of another process.

6.1a(6) Performance Requirements: Our design process requirements include the establishment of performance measures in compliance with our internal policies as well as law and regulatory requirements and standards. We maintain concurrent accreditation in good standing with the Joint Commission on Hospital Accreditation, the College of American Pathologists the Nuclear Regulatory Commission, the National Council on Quality Accreditation and the Rehabilitation Accreditation Commission. Site-visits from the VA Inspector General and the Office of Occupational Safety and Health Administration help us assure that we are in regulatory compliance.

KEY PROCESSES AND PERFORMANCE REQUIREMENTS

Key Processes	Day-to-Day Applications	Service Delivery Ownership	Examples of Performance Measures	Patient/ Other Stakeholders Contributions
Health Care				
• Primary Care • Acute Care • Specialty Care • Mental Health Care • Long Term Care • Diagnostics • Therapeutics	Promote healthy living practices and habits; Advising smokers to quit (Figure 7.4E); Shorter wait time for appointments (Figure 7.1 L-M); Pneumococcal vaccination (Figure 7.4L); Bar Code Medication Administration; Disease management; Surgical care; Substance abuse; Post Traumatic Stress Disorder screening; Homeless Program; Nursing Home Care; Home Based Primary Care; Laboratory; Pharmacy; Prosthetics	Local/Network Care Lines; Local/Executive Leadership Councils; Executive Committees of the Medical Staff; Nursing Clinical Practice Councils; Performance Management Council; Transforming Systems Performance and Quality Council	Clinical Practice Guidelines Measures; Prevention Index (Fig. 7.1A-P); IHI Waits and Delays; Mental Health 30-Day Follow-Up (Fig. 7.1A); Bed Days of Care (Figure 7.4F); Pharmacy Cost Increases (Figs. 7.2D-E); Major Depression Screening (Fig.7.1B).	Inpatient Satisfaction Surveys; Outpatient Satisfaction Surveys; Quick Cards; Patient Advocate Report
Business and Support Processes				
• Information • Environment and Facility • Human Resources • Fiscal Planning • Performance Management	Computerized Patient Records; Credentialing and Privileging; Hardware/ Software Integrity; Grounds and Facility Maintenance; Nutrition and Food Service; Patient/Staff/Visitor Safety; Occupational Workers Compensation Program; Equal Employment Opportunities; Complaints Awards and Recognitions Program; Contracting/ Fee Basis; MCCF/ Encounter Coding; Volume Discounts	Local /Network Care Lines; Local/Executive Leadership Councils; Strategic Information Systems Council; Transforming Systems Performance and Quality Council; Engineering Council; Human Resources Council; Performance Management Council	User Surveys; Security Audits; Work order man-hours; Cost per Patient Meal; Lost Time Claims Rate; Equal Employment Opportunity Complaints; Goal Sharing Participation; Turnover Rates; Fiscal Reconciliation's; Aging of Accounts; Third Party Insurance Collections; InterQual Criteria for Utilization Management	Inpatient Satisfaction Surveys; Outpatient Satisfaction Surveys; Quick Cards; Patient Advocate Report; Employee Satisfaction Surveys; Employee Collaboration Tool
Supplier Processes				
• Maximizing Supplier Partnering	Prime Vendor Contracts Fee Basis	Acquisition and Materiel Management; Network Authorization Office	Contract standardization; Volume discounts; Stock on-hand	Employee Satisfaction Feedback; Patient Satisfaction Feedback; Patient/Partner Satisfaction Feedback

6.1.a(7) Coordination and Testing: Our health care service design and delivery processes are coordinated through local boards and committees with oversight by the Transforming Systems Performance and Quality Council. Among the methods we use to ensure trouble free and timely introduction of healthcare services are the use of pilot programs and active participation in the design testing of new VA-wide initiatives.

6.1.b(1,2&3) Health Care Service Delivery Processes: Our organization's key processes and examples of day-to-day applications, performance requirements and measure indicators are illustrated in **Fig. 6.3.** Our patients are provided with multiple means to access information about our healthcare program and provide feedback for Network 2's consideration in its health care service delivery processes. Programs and resources include the Network 2 Rights and Responsibilities of Patients policy, the Personal Health Guide which educates patients on preventive health, the Veterans Health Benefits Booklet which defines veteran healthcare benefits and the Patient Handbook which identifies sites of care and services available in our Network. Our key care/delivery processes are linked to the patient directly through meeting their needs and maintaining satisfaction. The control of these processes is done through the use of Plan-Do-Study-Act methodology as illustrated in **Fig. 6.5**.

6.1b(4) Key Performance Requirements: The same improvement process is used to define, improve and evaluate network and local results against performance targets. In addition to the examples of improvement activities described in **Fig. 6.4**, timely appointments were of expressed value to veterans and our One-VA partners (compensation and pension exams for VBA). As a result of a Network-wide focus, a site-centered set of initiatives was begun in 1999 in conjunction with the National Institute for Healthcare Improvement. Using quality improvement techniques, teams achieve simultaneous yet site-specific rapid recovery. Five of six clinics have now reduced wait times to below 30 days (Fig. 7.4A), achieving VA's highest satisfaction relative to waiting times.

6.1b(5) Performing Inspections for Improvement: Minimization of Error occurs as a function of clinical care processes through the use of Clinical Practice Guidelines to minimize variation. This allows us to consistently monitor and audit indicators based on standardized care practices, and provides us with performance measures that allow for our constant review and comparison with the standard of care in the community.

Our Risk Management Program encourages the open reporting of errors. We provide an atmosphere that encourages complete reporting, creating the model of a new "no blame" culture that is leading the healthcare industry. The National Center for Patient Safety (NCPS) recently contacted Network 2 asking for permission to share nationally as a best practice, one of the Root Cause Analyses that was performed by Network 2 regarding an outpatient suicide. In doing so, we provide optimal validity and analysis of process issues, promote learning from the broadest possible pool of healthcare providers, and support rapid dissemination of lessons learned. We utilize internal, external and in-process criteria, as well as customer feedback to ensure that our support processes, design and development functions as we had intended. Examples of prevention-based processes include site safety inspections, mock surveys and on-going accreditation readiness reviews. This approach allows for more rapid identification and deployment of best practices across the Network and early detection of broader

PERFORMANCE IMPROVEMENT PROCESSES

Key Business Area	Performance Indicator/Measure	Improvement
Health Promotion / Disease Prevention	Clinical Practice Guidelines; Prevention Index	Development o integrated Primary Care model which provides Behavioral Healthcare in the Primary Care setting. MDD Screening
Human Resources	100% Employee Participation in Goal Sharing	Employees empowered to effect changes in delivery of services
Supplier / Partnering	100 % CBOC contracts must have quality improvement activities evident.	Contract standardization
Customer Service	Patient Satisfaction Scores	IHI Collaborative

Fig. 6.4

process problems.

6.1b(6) Process Improvement: The status of performance measures and sharing of best practices are continuously reviewed by Executive/Local Leadership and Performance Management Councils, employee forums, oversite committee meetings, storyboards, bulletin boards, work groups and monthly reviews. We communicate improvements through our Network 2 employee newsletters, electronic bulletins to all employees, inclusion on our Network 2 web site, Pulse Points Performance Measures Report, desktop Decision Support Objects, Network and local care line meetings, and discipline specific committees.

6.2 Business Processes: Business Processes are designed to provide medical care to eligible patients. Support services and processes are designed to meet the internal requirements of direct care providers, patients and external mandates such as regulations and accreditation standards. Requirements are identified so that compliance can be built into the process and work design.

6.2a(1,2&4) Key Business Processes: Our processes are illustrated in **Fig. 6.3** taking into account the internal and external requirements. The process stakeholders participate directly in the design/redesign process described earlier in **Figs. 6.1 and 6.5.**

6.2a(3) Design and Process Performance: Our healthcare organization designs, improves and deploys its business processes in the same manner as defined in **Fig. 6.5.** Internally, employee satisfaction surveys, performance measures, and Performance Management activities are monitored to identify compliance with and deviation from organizational expectations. Externally, potential vendors are encouraged to participate directly with the Network contracting staff before bid posting, in order to maximize alignment of bids to performance specifications.

6.2a(5) Managing Costs Associated with Audits: Inspection Cost Minimization practices include standardization of products and processes, minimization of process steps to reduce the potential for error, collaboration between functions, the sharing of lessons learned, cross training of staff, and ongoing training to preclude re-work. In addition, external review activities provide supplemental results monthly. This validates Network 2 performance findings with objective feedback as a strategy for cost avoidance.

6.2a(6) Business Process Improvement: Process improvement occurs by benchmarking against other Veteran Healthcare Networks and community organizations, seeking best practices, and maintaining open communications to allow for timely feedback from both those who perform the process and those who benefit from the process. The evaluation and process change steps of the design process are maximized. **(Fig. 6.5)** The Transforming Systems Performance and Quality Council is the clearinghouse for improvement ideas and the driving force to get them implemented through the Executive Leadership Council. **(Figs. 3.6, 4.2, 5.1, and 5.4)**

6.3 Support Processes: Network 2 sets expectations for suppliers in terms of performance improvement planning, technical specifications, directly and prospectively in the form of agreements. Face-to-face pre-bid discussions with each prospective supplier are conducted to promote better supplier understanding, resulting in bids and agreements that better meet specifications.

6.3a(1,2&5) Key Processes: Our Network's support processes, process requirements and indicators are illustrated in **Fig. 6.3** .

DESIGN & IMPROVEMENT PROCESS

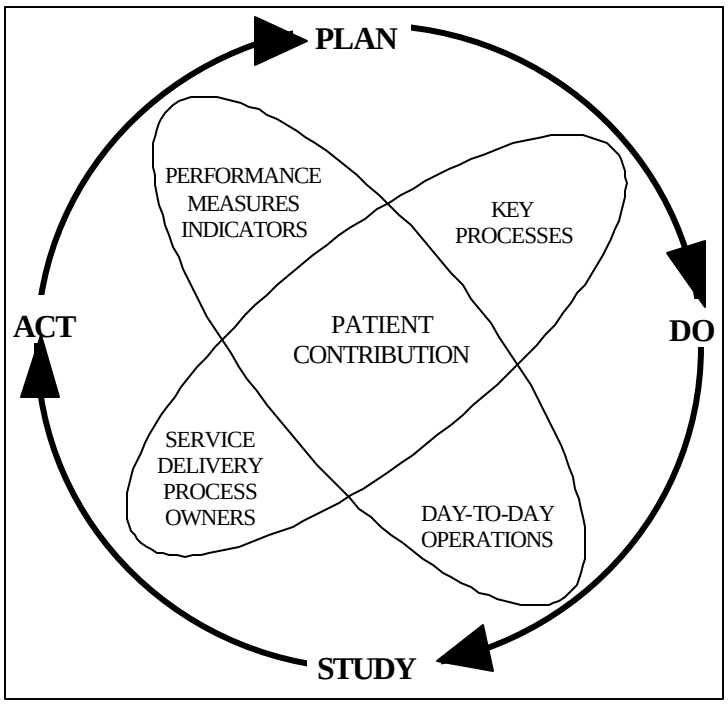


Fig. 6.5

We identify our key support processes based on an in-depth review and analyses that occur during our strategic planning process. Our support processes align with organizational responsibilities in our care line structure to best support clinical care processes, and they are linked to all of our critical success factors. Network 2 developed an exclusive supplier arrangement termed Prime Vendor, whereby better pricing, timeliness and quality of deliverables is facilitated. We have negotiated Blanket Purchase Agreements for standardized items used throughout the Network. These Blanket Purchase Agreements allow the network to order supplies at less than contract prices based on the volume of the supply ordered. The Network formed site-specific partnering relationships with private healthcare organizations for mobile medical vans, remote site outreach, specialized care for female veterans, acute/emergent medical services, and home oxygen services.

Our Network provides educational opportunities for all patients, families, employees and academic affiliates via the Network Education Council**.** Clinical research for veterans contributing to the improved health of veterans and the general public is evident through cancer programs at our tertiary sites.

6.3a(3) Designing Processes to Meet Requirements: Design and Process Performance include Prime Vendor arrangements and the addition of quality measurement requirements in contracts, both a direct result of improving the supplier/partner processes. Network 2 continually evaluates structure and process to find better, more efficient and less costly methods of delivering quality services. Support services and processes are designed to meet the internal requirements of direct care providers, patients and external mandates such as regulations and accreditation standards. Requirements are identified so that compliance can be built into the process and work design. Typically performance measurements are spelled out in the initial solicitation. These measurements may include accuracy, speed of processing, or other relevant issues. An example of this process would be the standard Community Based Outpatient Clinic contract. This contract went through two complete refinement cycles prior to implementation.

6.3a(4&6) Meeting Key Performance Measures: Day-to-Day Operations and Cost Minimization support processes are aligned with our critical success

factors for the monitoring of continued success. Various forums to review them are provided, such as the Decision Support Objects and Pulse Points Performance Reports, ensuring that all levels of the organization can participate in the continued success of daily operations. We have defined Network level policies and procedures that establish the criteria to be met by the key support processes. Standardizing the process helps us to minimize variation, allows us to use consistent measurement of indicators based on standardized data definitions, and provides us with performance measures that allow for our constant review and comparison among facilities in the Network, as well as the community.

6.3a(7) Performance Improvement: Support Process Improvement relies on regular performance reviews at both the Network and local medical center levels. On the Network level**,** the process indicators are a standing agenda item for our monthly Executive Leadership Council meetings and are the subject of our monthly Performance Management Council meeting. Our medical centers review the indicators on a site-specific basis at the monthly Local Leadership Council. Special cause variations, process variations, or poor performance, require the process owner to formulate a recovery plan addressing the cause of poor performance, corrective and preventive actions, service delivery ownership and timelines for amending the problem. We accomplish organizational learning and sharing through several venues, as described in **Cat. 6.1b(6)**.

7.1 PATIENT & CUSTOMER FOCUSED RESULTS

Behavioral Health-related Results

7.1A-Mental Health Follow-Up

Network 2 achieved VA best practice in 2001 with a follow-up rate of 97.9%, far surpassing the NCQA Mean of 71%. and approaching the best performer in New York State Best practices were shared at national conferences.

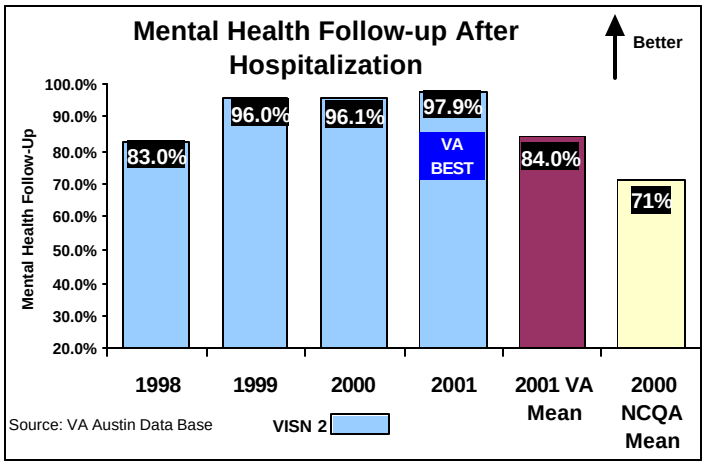


Fig. 7.1A

7.1B-Major Depression Screening

The percentage of patients receiving required intervention in the form of screening for major depression improved to **89%** in FY 2001, achieving VA best.

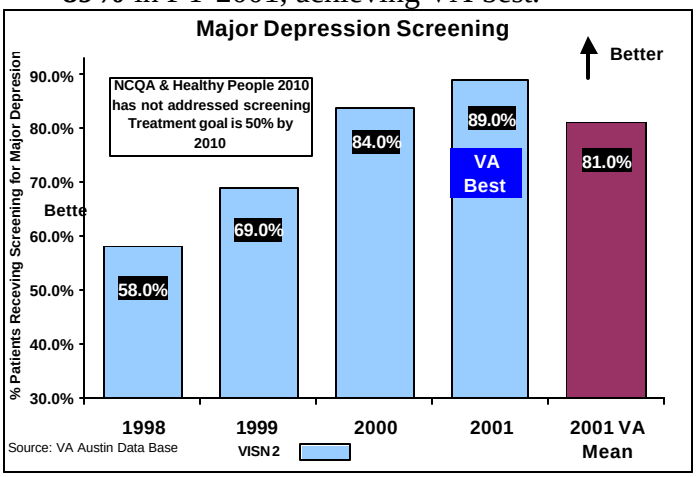


Fig. 7.1B

Studies indicate that screening 100 primary care patients would identify 31 patients with a positive screen, 4 of whom actually have major depression (VA Office of Quality & Performance)

7.1 C-Annual Assessment of Schizophrenia Patients for Abnormal Involuntary Movement

We led VA nationally in annual assessment of schizophrenia patients on antipsychotic drugs, also surpassing any known community standards, to prevent permanent facial ticks & other involuntary movements.

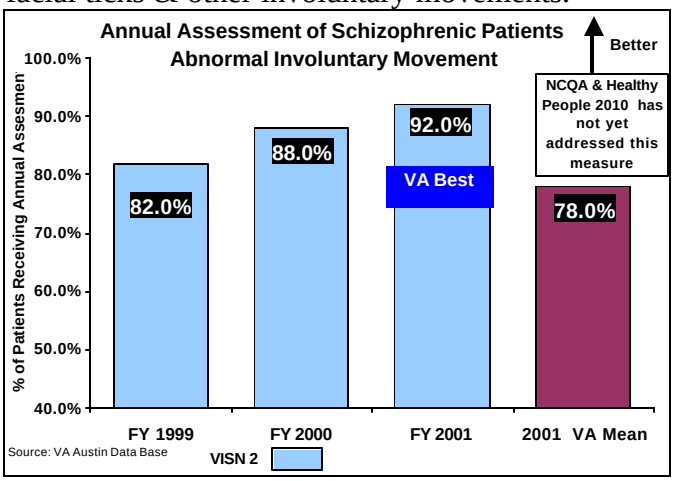


Fig. 7.1C

7.1D-Advising Smokers to Quit

The VISN 2 percentage of tobacco users counseled to quit smoking equaled 97% in 2001, near the VA best and far surpasses the NCQA 90th percentile. If all smokers were advised to quit at the 90th percentile, an additional 82,000 smokers would actually quit smoking (NCQA).

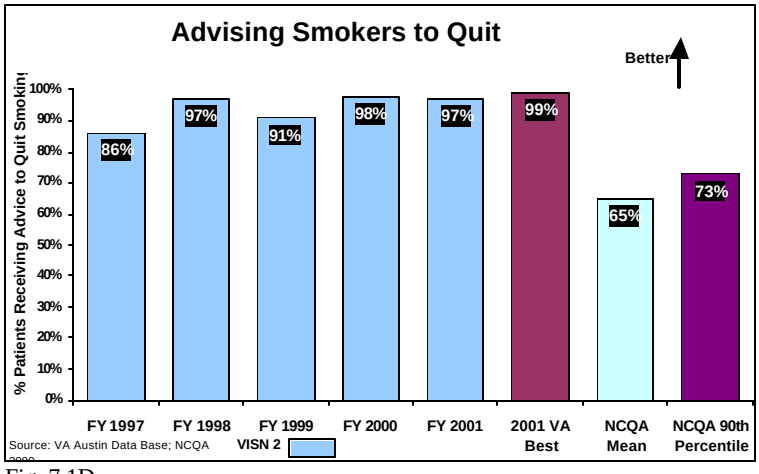


Fig. 7.1D

Cancer Screening

7.1E-Colorectal Cancer Screening

The percentage of patients receiving colorectal cancer increased to 69%, VA best practice in 2001.

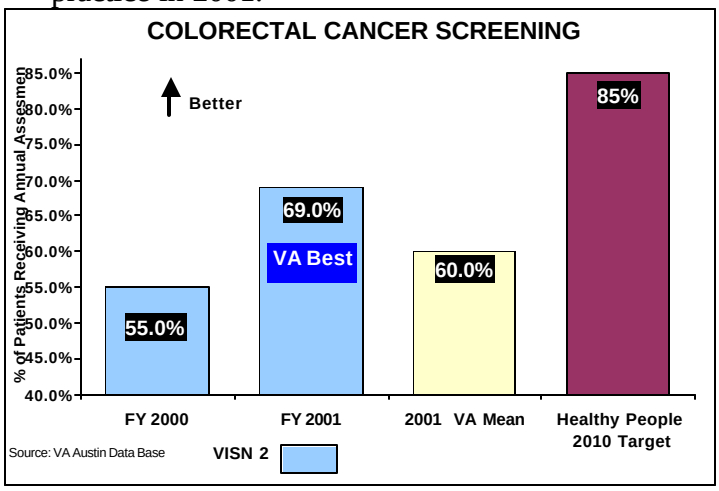


Fig. 7.1E

7.1F-Cervical Cancer Screening

The percentage of patients receiving cervical cancer screening improved to 89% in FY 2000, surpassing the HMO national average, approaching Healthy People 2010 goals. Compliance at the NCQA 90th percentile (83%) would detect 900 additional cases nationally (Network 2=89%).

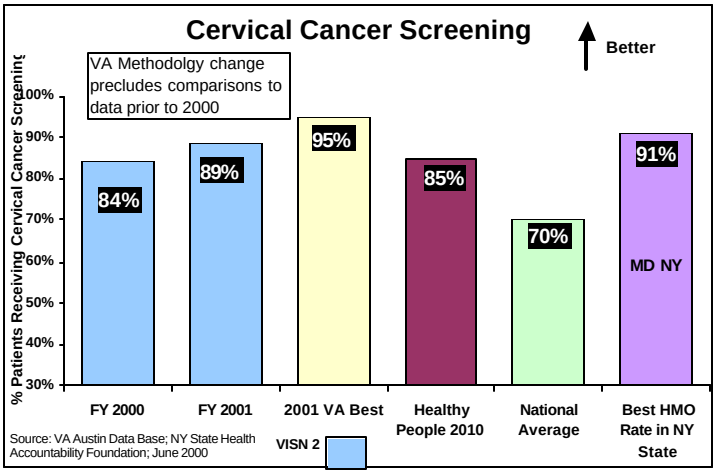
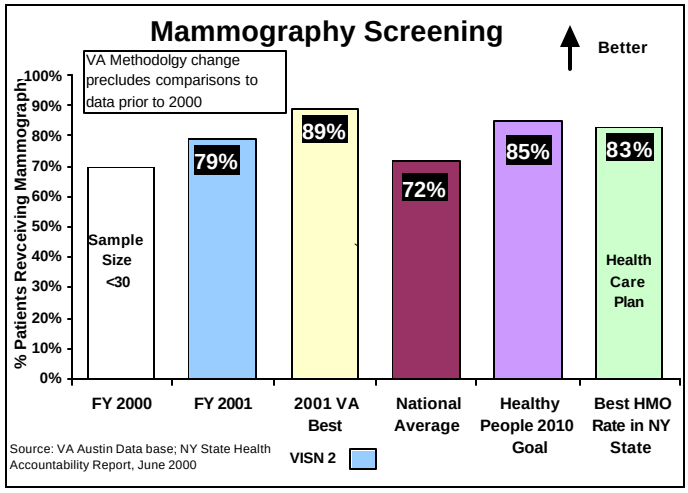


Fig. 7.1F

The use of automated clinical reminders will be used to further improve adherence to recommended screening practices, to achieve the VISN 2 target of 94% in 2002.

7.1G-Mammography Screening

The percentage of female patients receiving breast cancer screening through mammography equaled 79%, above the



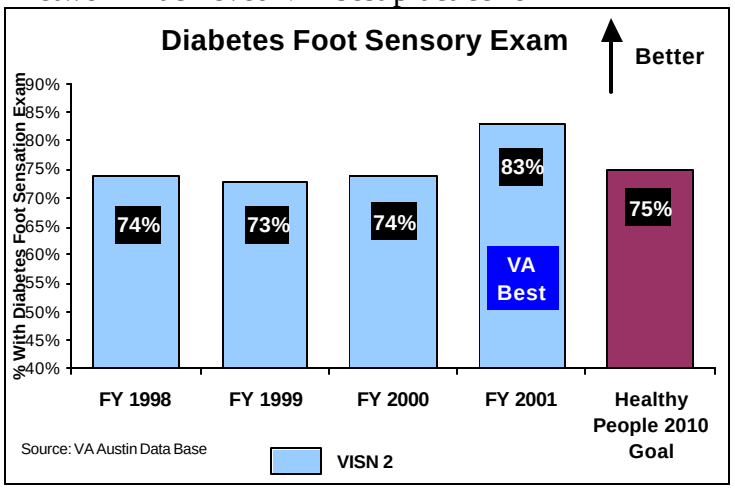
national average and Healthy People 2010 Goal. Mammography screening has been shown to reduce mortality by **20-40%** among women 50 or older. Compliance at the NCQA 90th percentile (82%) benchmark, would help to detect an additional **10,000** cases nationally

Fig. 7.1G

Diabetes Management

7.1 H-Diabetes Foot Sensory Exams

Network 2 achieved VA best practice for



foot sensory examinations. These represent major preventive care interventions, which results in significantly reduced incidence of lower extremity amputations.

Fig. 7.1H

7.1 I-Amputation Rate per 10,000 Diabetic Patients

Through early prevention and detection of vascular disease among diabetic patients, specifically through pedal pulse and foot sensory examinations, lower extremity amputations have been significantly reduced between 1997 through 2001. Resulting rates compare favorably with New York State rates as reported by the State Health Department

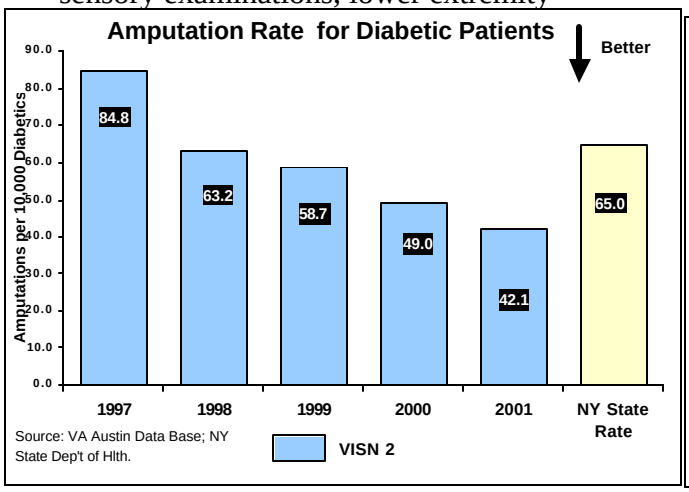


Fig. 7.1I

7.1 J-Admission Rate per 1000 Diabetics

Network 2 decreased its admission rate by 49% since 1997, 3rd lowest among 22 Networks, 17% below the VA mean.

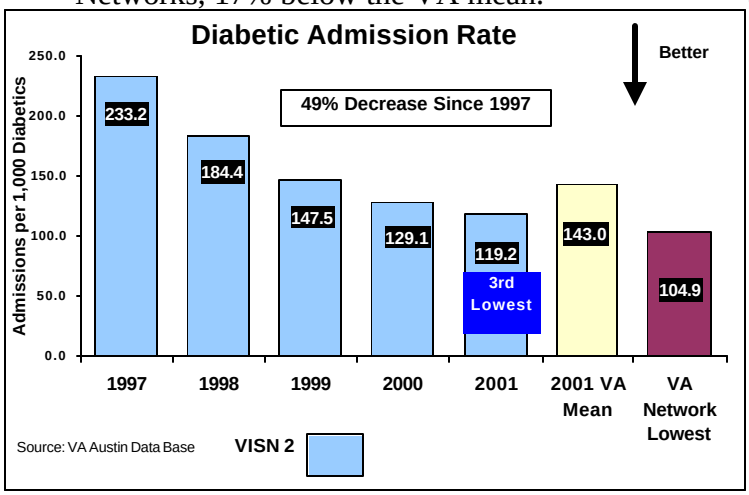


Fig. 7.1J

This improvement is a result better use of alternatives to inpatient care.

Hypertension Management

7.1 K-Diabetes Hypertension Control

The percentage of diabetic patients with blood pressure below 140/90 increased to 56%, surpassing the Health People 2010 goal of 50%.

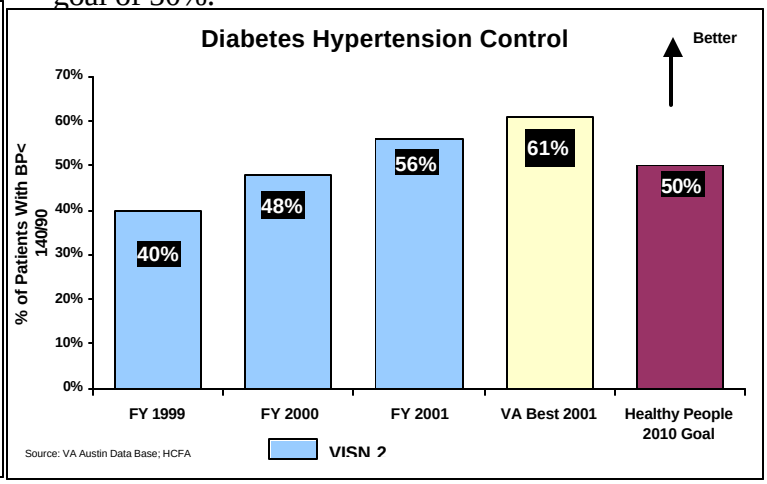


Fig. 7.1K

7.1 L-Controlling High Blood Pressure

The percentage of patients with blood pressure below 140/90 increased to 53%, surpassing the Health People 2010 goal of 50%. Improved adherence to clinical guidelines will further improve hypertension management, toward the goal of achieving the 60% rate by 2003.

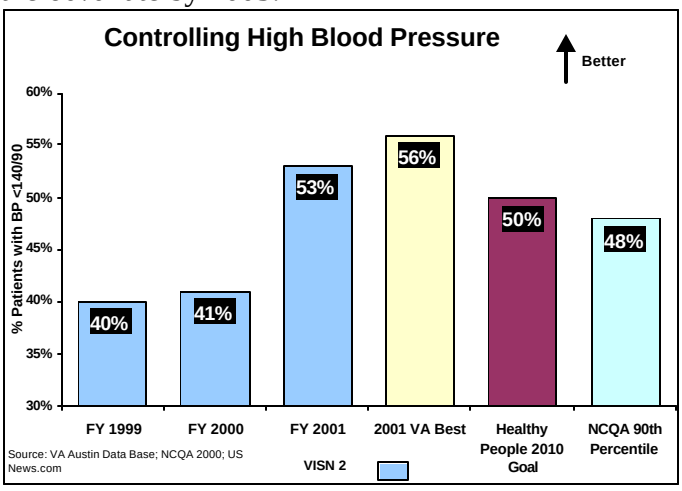


Fig. 7.1L

Ischemic Heart Disease Management

7.1M-Aspirin Administration within 24 Hours In accordance with the clinical practice guideline for patients with ischemic heart disease, aspirin was given within 24 hours of an acute myocardial infarction 92% of the time. This far surpasses the regional community rate as reported by the Health Care Finance Administration (HCFA) of 81%, or the HCQIP median rate (84%).

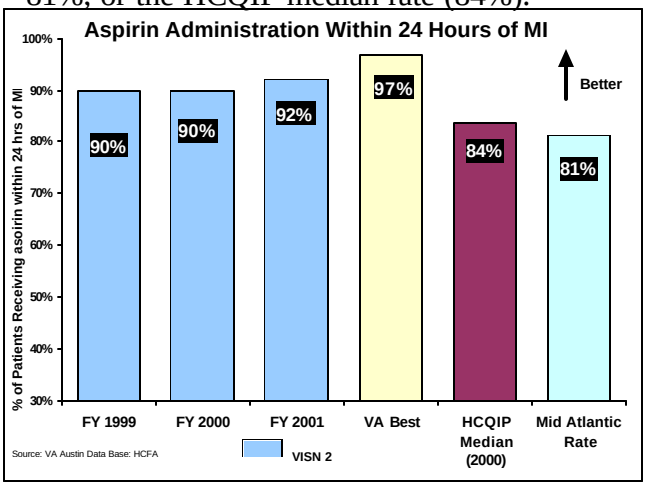


Fig. 7.1M

Taking aspirin following an acute myocardial infarction contributes to an important goal following a heart attack-to prevent future complications in the form of increased mortality and morbidity.

7.1N-Beta Blocker Treatment After Heart Attack The percentage of patients given Beta-Blocker therapy following an acute myocardial equaled 71% in 2001 Improved prescribing of beta blockers is a foremost goal and included in our crucial metrics (**Fig 2.9**) Elderly patients receiving beta blockers following a heart attack are 43% less likely to die in the first 2 years following the attack (Journal AMA).

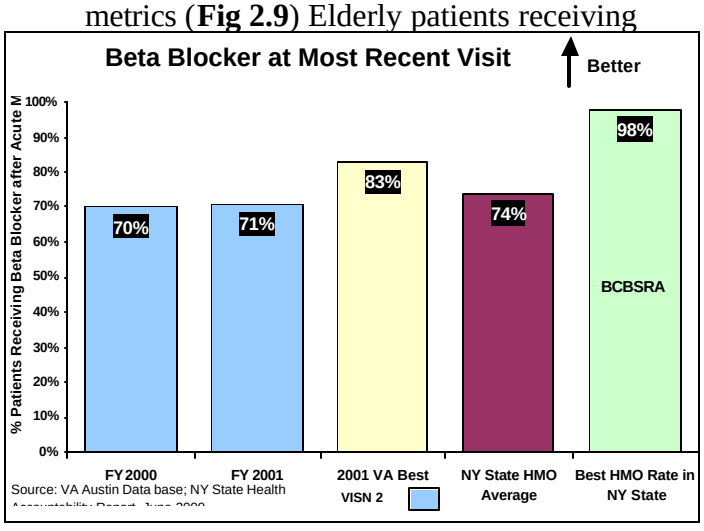


Fig. 7.1N

Immunization Practices for Prevention

7.1O-Patients receiving Pneumococcal Vaccination

The percentage of eligible patients receiving pneumococcal vaccine equaled 79%; well below the Healthy People 2010 Goal. Improved use of Pneumococcal Vaccine is a foremost goal and included in our crucial metrics **(Fig 2.9**)

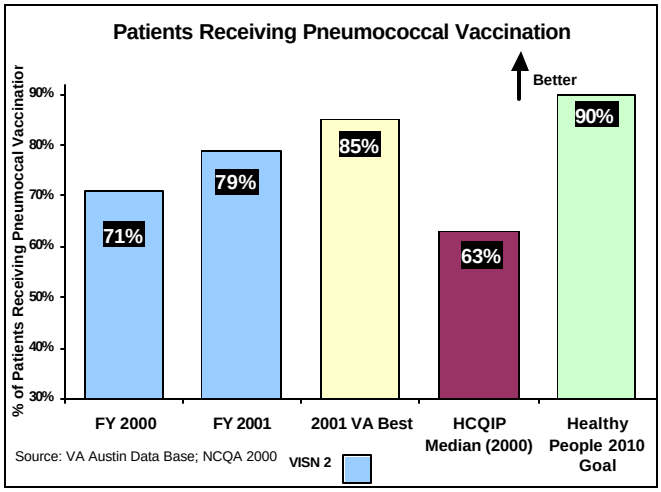


Fig. 7.1O

7.1P-Influenza Immunization

The percentage of eligible patients vaccinated against influenza increased to 70% in 2001 well below the Healthy People 2010 Goal of 90% and the Health Care Quality Improvemnent Project (HCQIP median). Improved use of flu shots is a foremost goal and included in our crucial metrics **(Fig 2.9)**

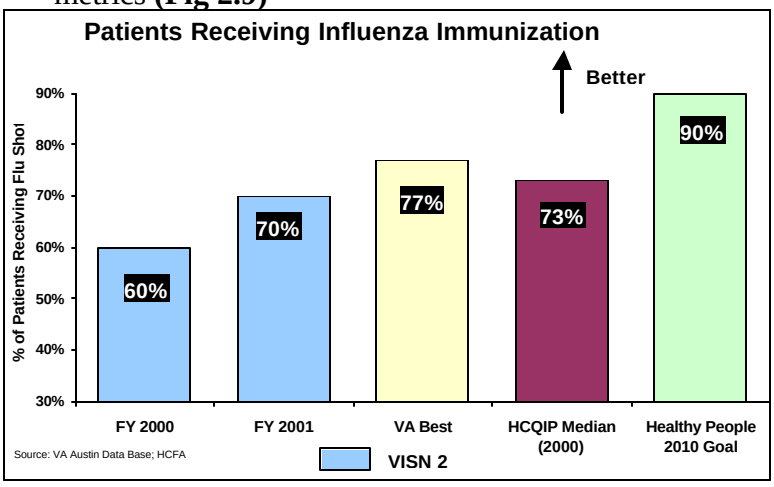


Fig. 7.1P

7.1Q-Overall Satisfaction. Network 2 achieved VA's 2nd highest rating of overall satisfaction among 22 networks nationwide, with a **70%** of patients rating care very good or excellent, comparing favorably with

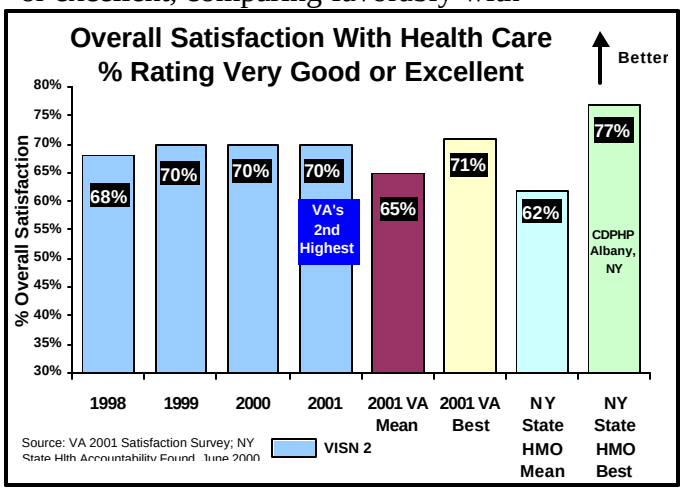


Fig. 7.1Q

NY State HMO and VHA scores

7.1R-Overall Satisfaction-% Good to Excellent

93.2 % of patients rated care in the good to excellent range, VA's second highest rating and very near VA best.

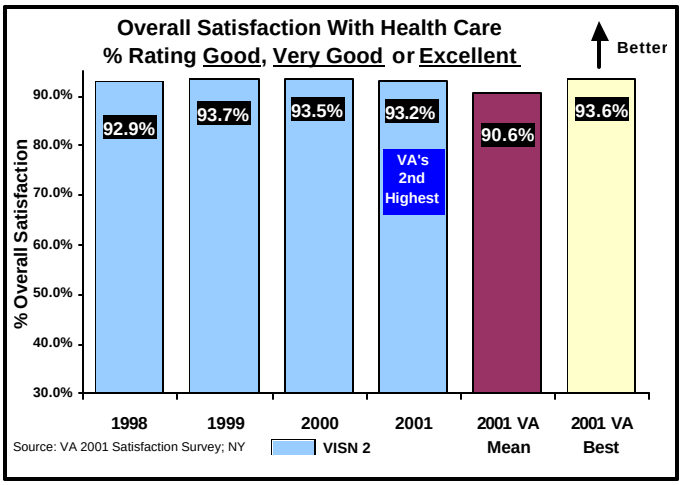


Fig. 7.1R

This coincides with Network 2's relatively low problem rate as shown in greater detail in **Fig. 7.1W**. Customer Service Council initiatives have sustained high levels of satisfaction, many of which were cited as best practices **(Fig 7.4J).**

7.1S-Patients Rating Care Poor

Only 1.4% of patients rated care poor, tied for VA's best and supported by high satisfaction rates for those aspects of care shown in graphs **(Fig- 7.1W).**

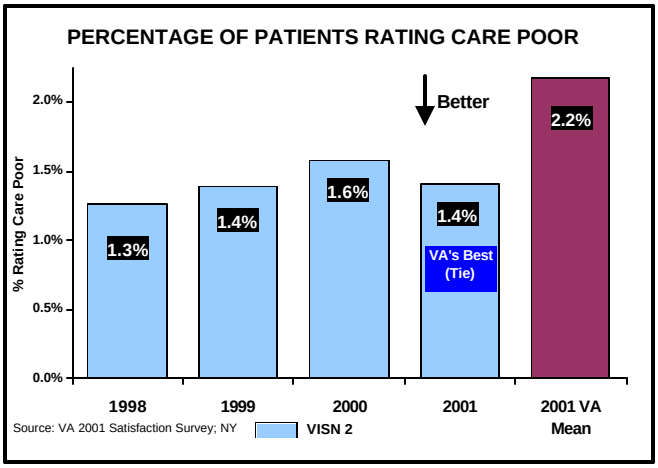


Fig. 7.1S

7.1T-Overall Satisfaction by Major Market

Despite VA's 2nd highest overall rating (70% very good or excellent), a wide range exists among network facilities, with Canandaigua and Syracuse scoring at HMO

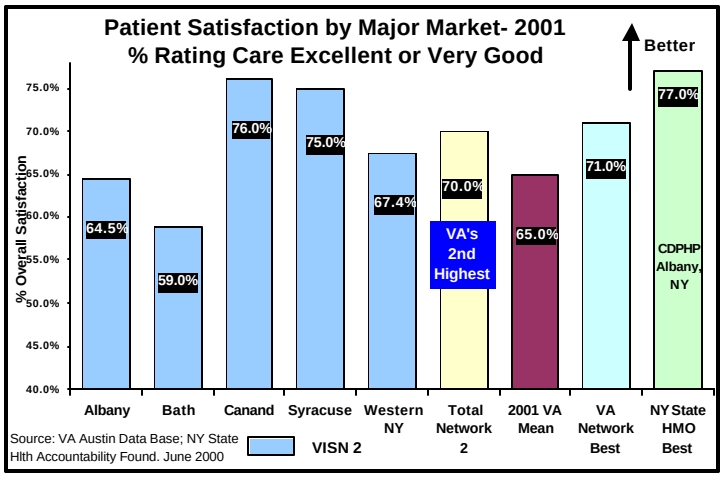


Fig. 7.1T

best levels. Network-wide customer service initiatives cited in Category 3, staff training to improve courtesy and emotional support, and improved waiting times through the IHI Collaborative will serve to further improve these rates in 2002-2003.

7.1U-Satisfaction by CBOC
We further break down our major market segments into community-based clinic scores with scores analyzed and presented to staff at each of our clinic locations.

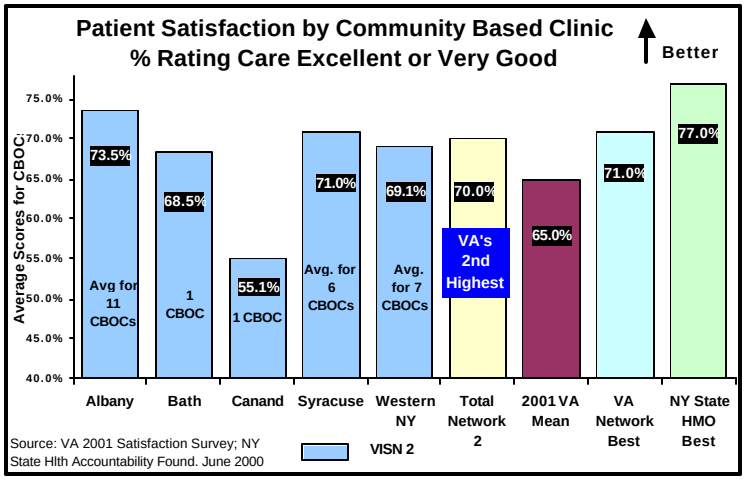


Fig. 7.1U

7.1V-Satisfaction for Access to Care
We achieved VA's highest rating of 89.3%, near the NY State HMO best (CDPHP).

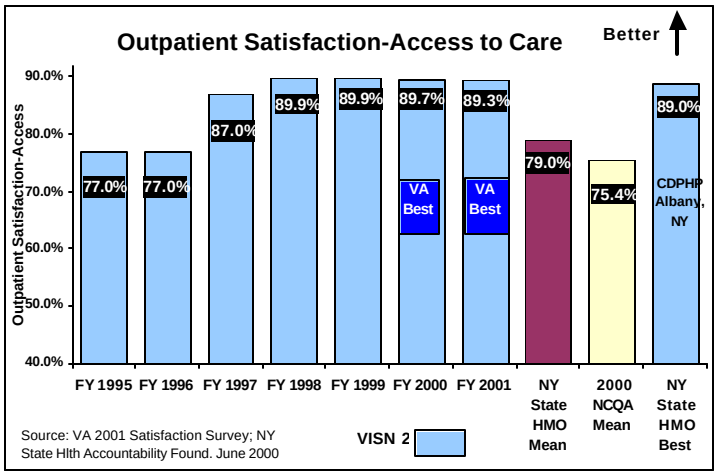


Fig. 7.1V

7.1W-Satisfaction by Component-2001 Survey
Satisfaction scores, as measured by the percentage of problems reported were 2 standard deviations better than the VHA average for 8 of 10 measures. Integrated primary care (with behavioral health and geriatrics) to improve continuity, additional staff training, and improved waiting times will further improve these scores in 2002.

7.1X-Clinic Waiting Time Satisfaction
Network 2 achieved VA's highest rating of 83%, demonstrating continued improvement since 1998. NCQA or community health scores are unavailable.

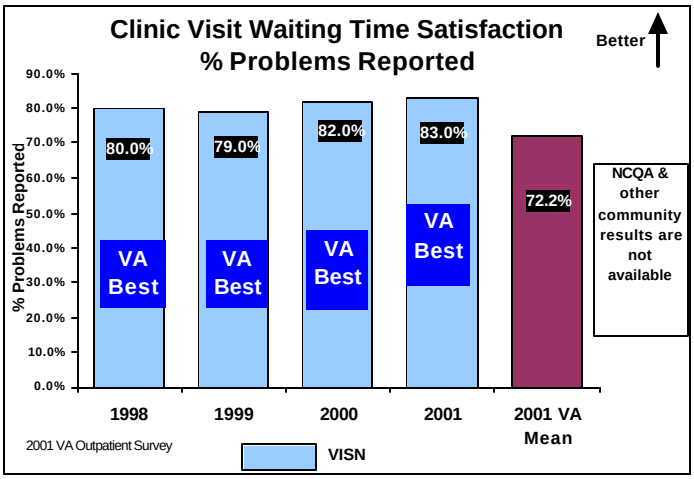


Fig. 7.1X

7.1Y-Satisfaction for Courtesy-Network 2 achieved VA's 2nd highest rating of 95%.

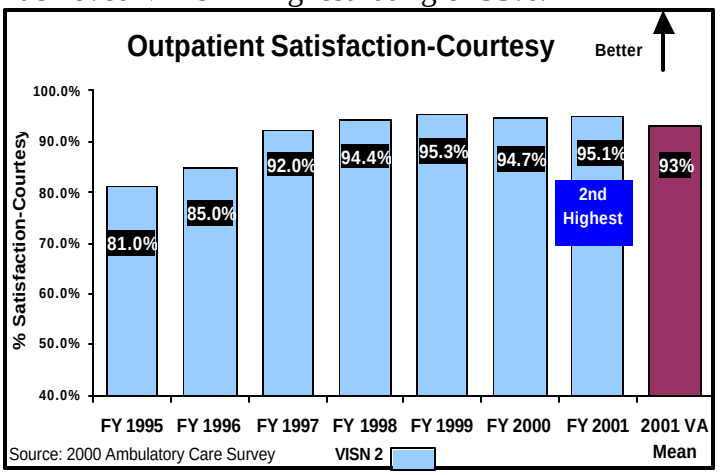


Fig. 7.1Y

OUTPATIENT SATISFACTION BY COMPONENT-2001

Component	% Problems Reported: Network 2	National Average	VHA Best Practice	2 Stand. Deviations Above (+) or Below (-) VA Mean
Access	10.7	12.1	10.7	(+)
Continuity	25.8	23.3	18.3	
Courtesy	4.9	7.0	4.7	(+)
Emotional Support	18.7	19.4	15.5	
Overall Coordination	26.1	27.2	24.4	(+)
Patient Education/ Info.	28.4	29.8	26.2	(+)
Pharmacy	12.7	16.1	11.0	(+)
Preferences	18.5	20.1	17.1	(+)
Specialist	24.0	27.0	24.0	(+)
Visit Coordination	14.4	15.8	13.0	(+)

Source: 2001 VA Outpatient Satisfaction Survey

Fig. 7.1W

7.1Z-Satisfaction for HBPC-Network 2 achieved a VA best score of 93% as compared to the VA Mean of 79.6%. VA's 2001 Scores have not yet been released.

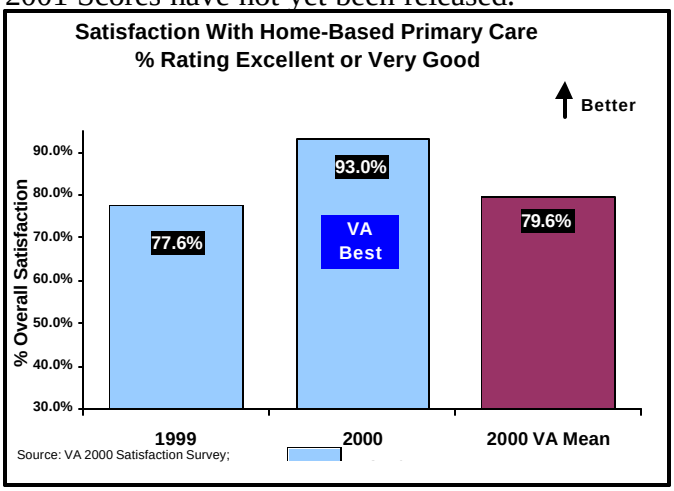


Fig. 7.1Z

7.1AA-Returning for VA Care

Over 87% of patients would return even if care was free outside of VA, 0.1% below VISN 4.

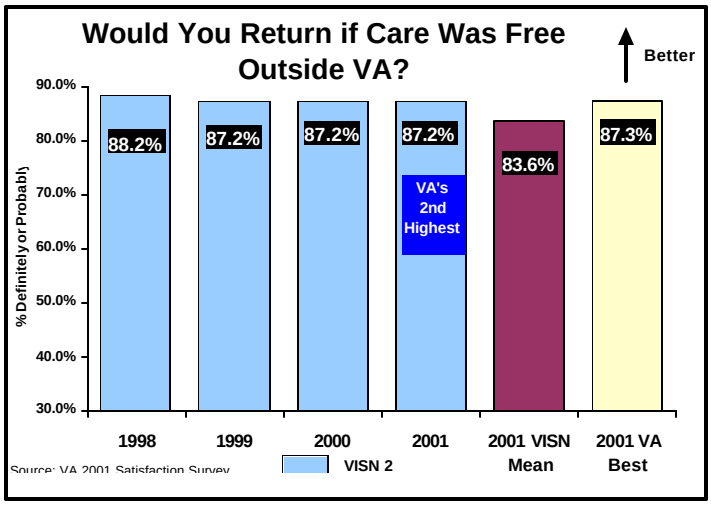


Fig. 7.1AA

7.1AB-Reasons for Not Using VA Health Care

Veteran Non Users were surveyed in order to better understand reasons for not seeking VA health care. Findings revealing uncertainty over eligibility prompted the issuance of eligibility documents and fliers as well as changes to Network 2 Website to help attract new patients.

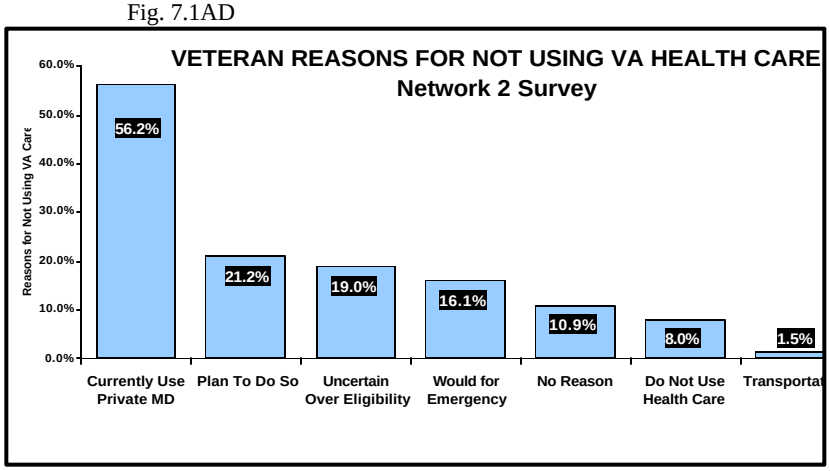


Fig. 7.1AB

7.1AC-Rating Specialty Care Good to Excellent

We achieved a score of 84.9% for Specialty Care, VA best practice in 2001.

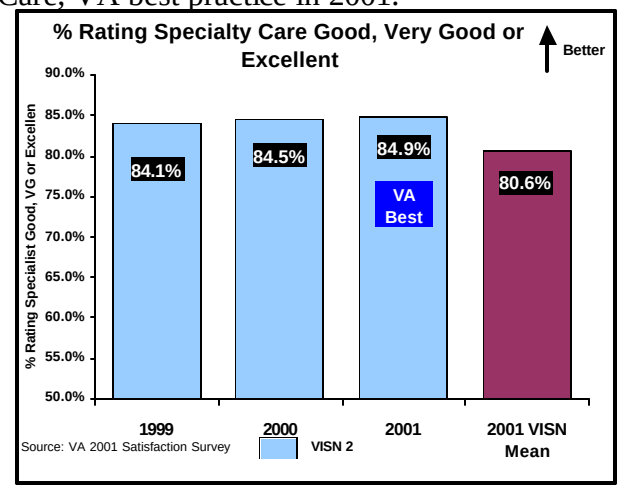


Fig. 7.1AC

7.1AD-VA Care As Good as Anywhere

We achieved VA's highest score with 83.5% of patients reporting that VA Care is as good as provided anywhere vs. the VA mean of 78.9%.

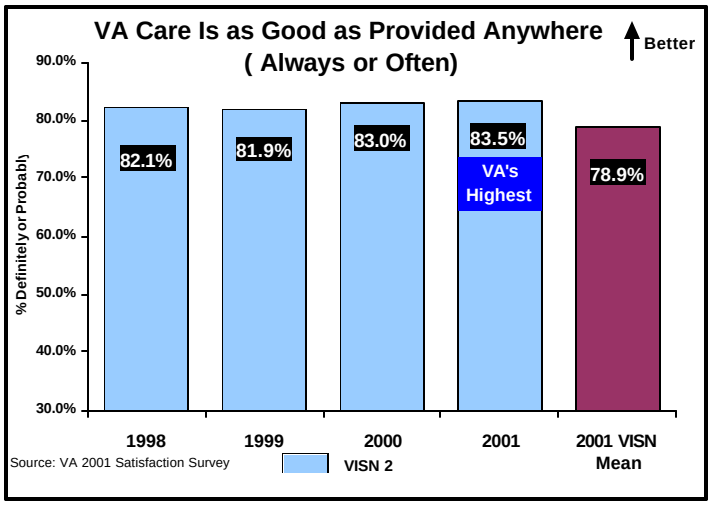


Fig. 7.1AD

7.1AE-Quick Card Satisfaction-Overall

Our own Network-developed satisfaction tool, Quick Cards, provides daily assessment of satisfaction, and opportunities for immediate front-line problem resolution.

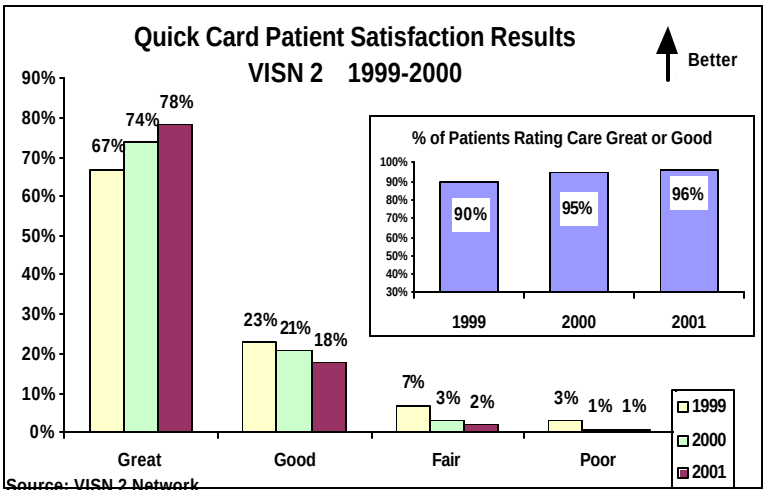


Fig. 7.1AE

7.1AF-Quick Card Satisfaction by Major Market

7

Significant improvements were noted for each major market, most notably in Syracuse and Western New York.

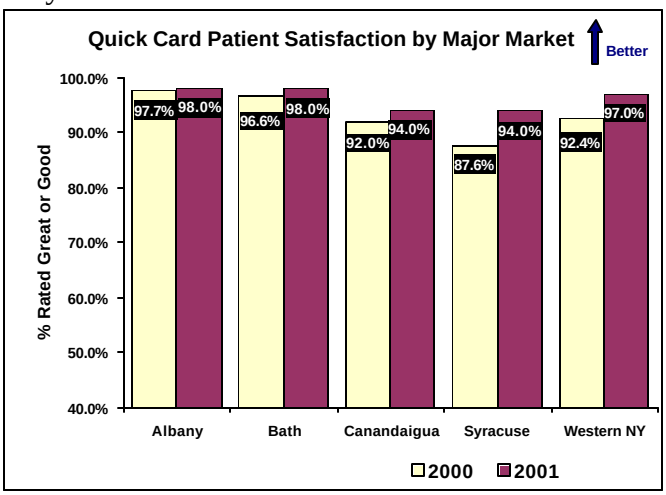


Fig. 7.1AF

The greatest utility of Quick Cards is the immediate action taken by staff to resolve the problem for the patient. The comments section is reviewed by staff on a daily basis, with scores tabulated and examined network-wide each quarter.

7.1AG-Quick Card Satisfaction-3 Components

Improvements were noted for facility cleanliness and for health information and advice.

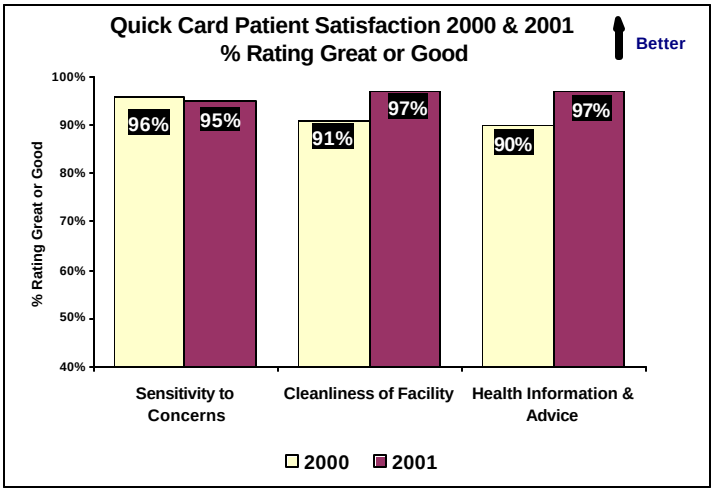


Fig. 7.1AG

7.1AH-Quick Card Satisfaction-4 Components

Improvements were identified in staff courtesy, timeliness of service and confidence in provider.

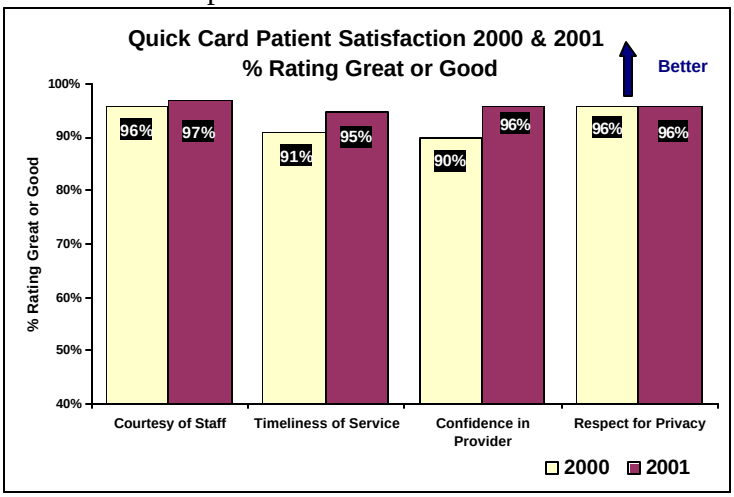


Fig. 7.1AH

Reviews of the Quick Card process, including the feedback reports from prior Kizer And Carey site visits, have led to the next iteration of Quick Cards, in which the adjective ratings have been better aligned with VA and NCQA HMO ratings.

FINANCIAL AND MARKET RESULTS

Cost-Related Issues

7.2A-Cost per Patient

Network 2 reduced cost per patient by 20.9% between 1997 and 2001, the 2nd greatest reduction in unit cost among all 22 VA networks. This represents a 41.5% reduction adjusting for inflation. Unit costs compare favorably to annual U.S. health plan costs among 600 large companies.

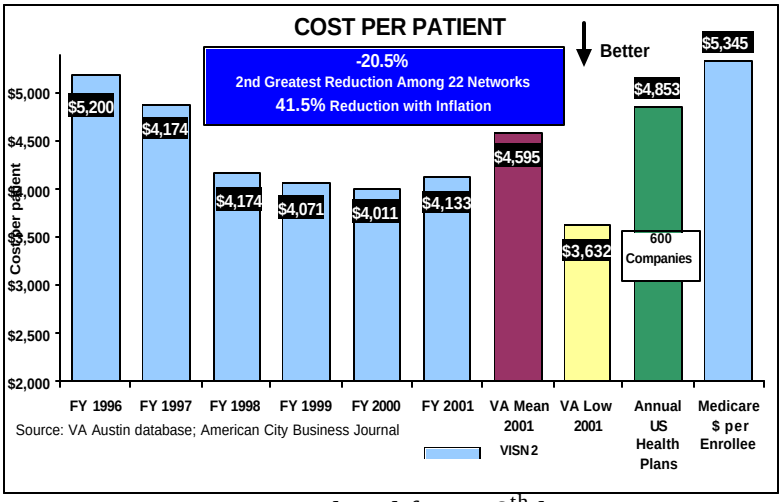


Fig. 7.2A

Unit cost was reduced from 18th lowest among 22 networks in 1996 to 4th lowest.

7.2B-ClinicalCost per Patient

Clinical cost per patient is 3rd lowest among 22 networks and has remained stable despite the effects of medical inflation.

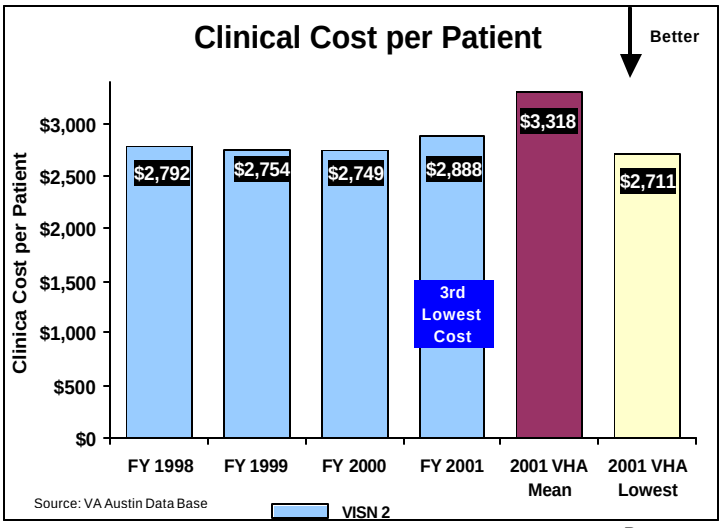


Fig. 7.2B

7.2C-Staffing Productivity

A 34.4% increase in staff productivity has resulted from restructuring of health care services, cross training of staff and application of new technologies. This represents the greatest increase in productivity among all networks since 1996. The redirection of care to outpatient, home and community settings has transformed health care delivery within our organization and is most significant in the context of the improved quality and satisfaction scores **(7.1A-Z)**

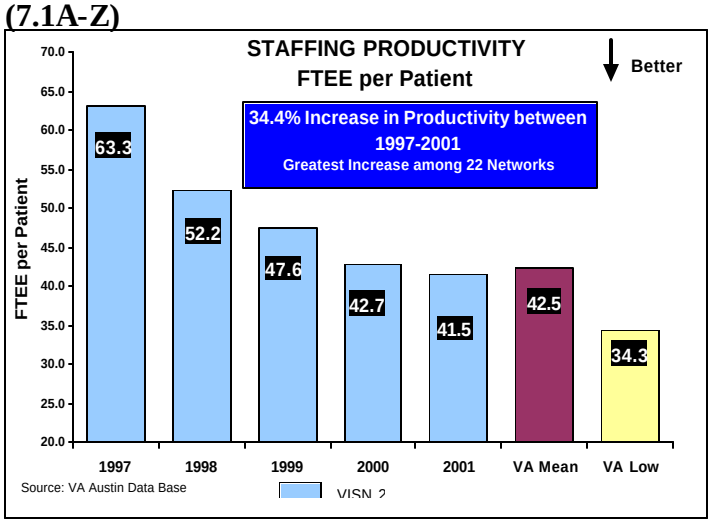


Fig. 7.2C

7.2D-Pharmacy Cost per Patient

Pharmacy costs per patient have been effectively managed, with Network 2 generating the 3rd lowest unit cost among all VA networks.

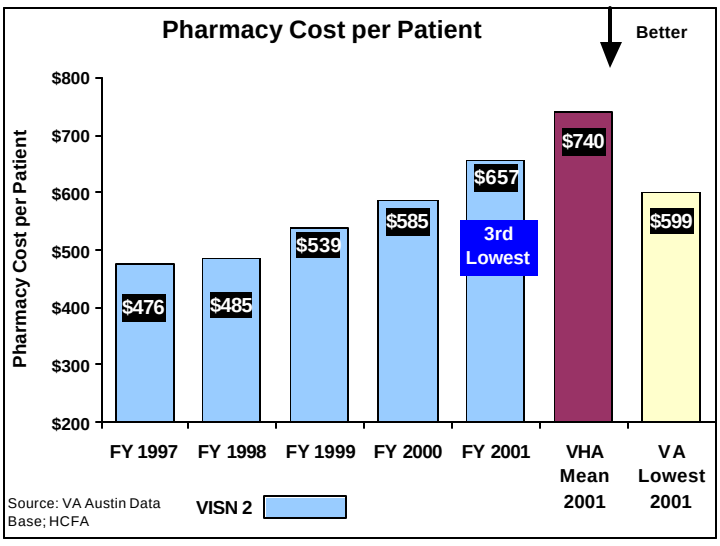


Fig. 7.2D

7.2E-Pharmacy Cost Increases

Annual Pharmacy cost increase equaled 9.5% between 1997-2001, as compared to annual U.S. pharmacy increases of 15%. Successful control of drug costs resulted from Network-wide utilization summits to address utilization patterns, standardization of non-formulary exceptions and electronic drug usage evaluations.

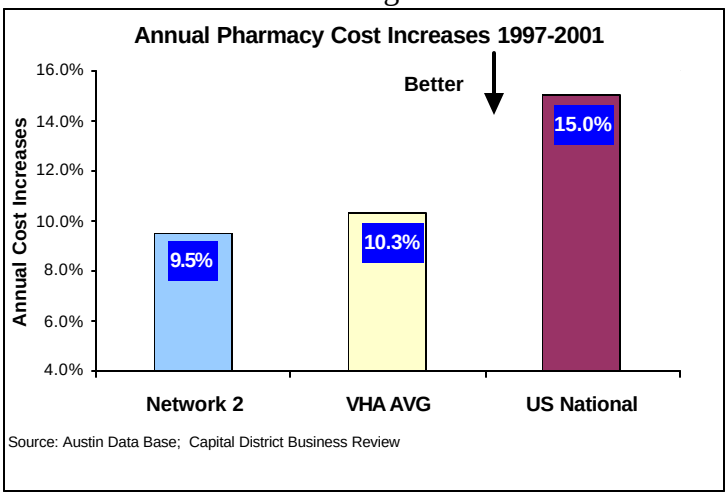


Fig. 7.2E

7.2F-Laboratory Cost per Patient

Lab cost per patient decreased by 29% between 1997-2001, with Network 2 generating the 4th lowest cost nationally. Network-wide Utilization summits have been conducted, with plans for continued assessment of current spending. The Laboratory Expert System (LES) will help to further optimize utilization.

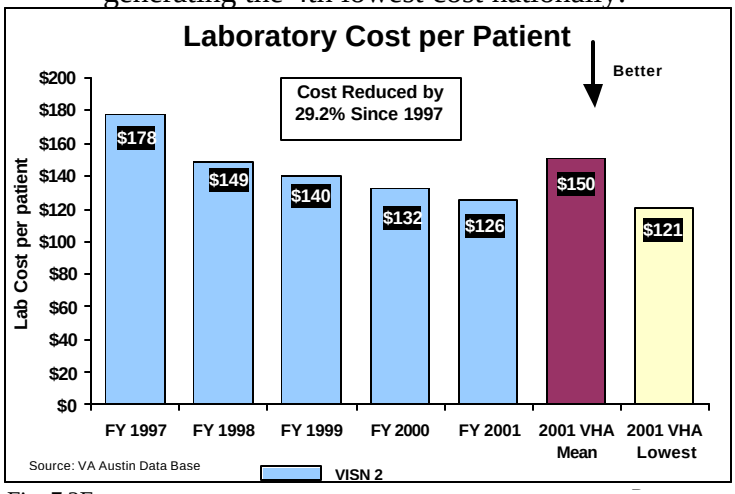


Fig. 7.2F

7.2G-Prosthetics Cost per Patient

Prosthetics costs per patient have been effectively managed, with Network 2 generating the 3rd lowest unit cost among all VA networks.

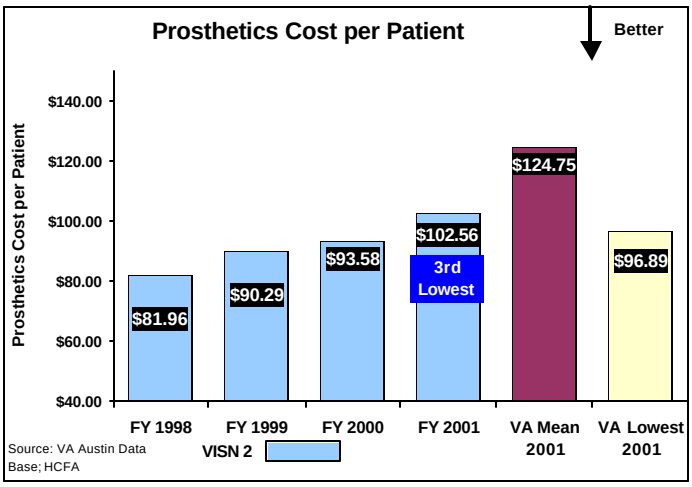


Fig. 7.2G

7.2H-Research Expenditures

Research expenditures increased by 5 percent in 2001 in support of Network 2's goal of increasing research funding in areas of importance to the veteran population. In order to enhance research activities, Network 2 established a Research Fund, designed to fund research support costs and infrastructure, identified as a VA best practice.

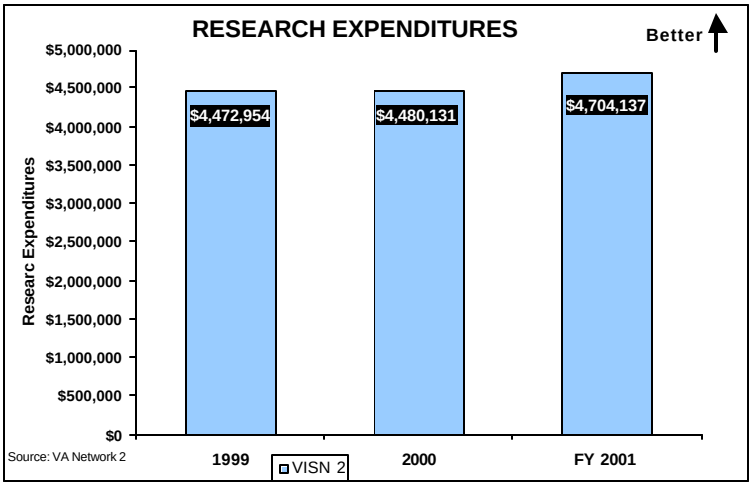


Fig. 7.2H

Alternate Revenue

7.2I-Medical Care Collections (MCCF)

2001 MCCF Collections increased by 15.2%, achieving the target of $18.1 million.

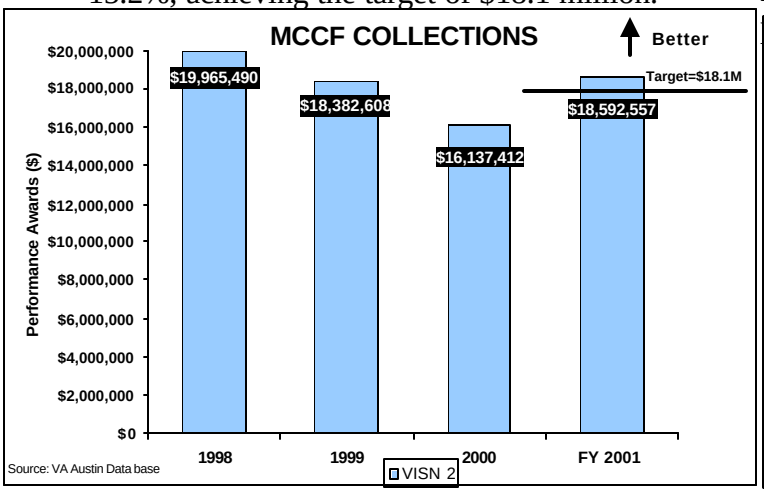


Fig. 7.2I

Improved billing and coding procedures and improved relationships with insurance carriers produced greater overall collections.

7.2J-Alternate Revenue (Non-MCCF)

Alternate revenue collections increased significantly in 2001 as a result of effective sharing agreements and selling of VA services within Upstate New York communities.

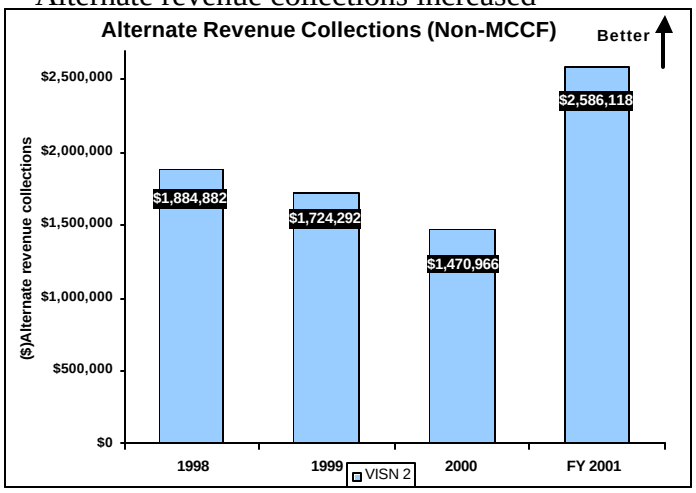


Fig. 7.2J

Market Penetration

7.2K-Veteran Market Penetration-

Network 2 achieved the 3rd highest market

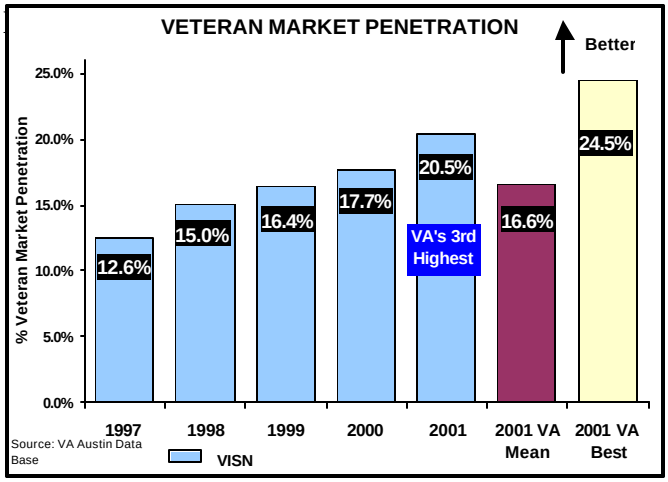


Fig. 7.2K

7.2L-Category A Veteran Market Penetration

Network 2 achieved the 4th highest market penetration in 2001, treating 39.5% of the highest priority population.

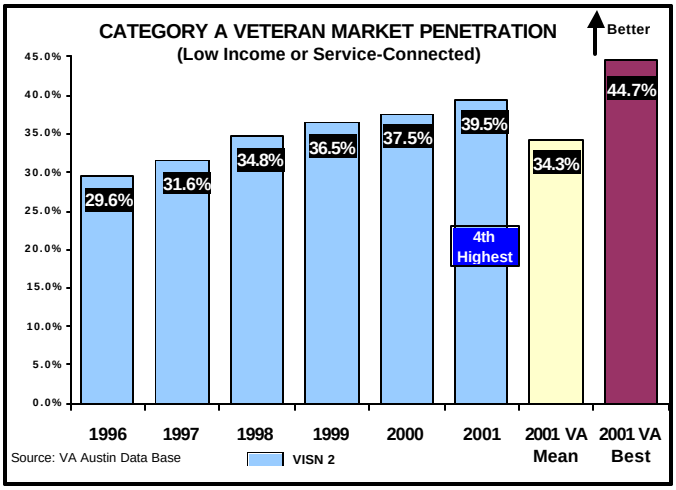


Fig. 7.2L

7.2M-Veteran Penetration by Maj. Market

Each of Network 2's major markets have shown significant increases though 2001, all of which are above the VA mean and approaching VA best-VISN 8.

Market Penetration by Major Market

Major Markets	1997	1998	1999	2000	2001	2001 VA Mean	2001 VA Best
Albany	12.4%	14.5%	16.7%	18.6%	**19.8%**	16.6%	24.5%
Bath	20.4%	24.5%	26.6%	27.8%	**30.7%**	16.6%	24.5%
Syracuse	13.2%	16.9%	18.6%	18.7%	**21.9%**	16.6%	24.5%
WNY	13.1%	15.4%	16.4%	19.1%	**22.6%**	16.6%	24.5%
TOTAL	**12.6%**	**15.0%**	**16.4%**	**17.7%**	**20.5%**	16.6%	24.5%

Source: VA Austin Data base

Fig. 7.2M

Patient Growth

7.2N-Patient Growth

Patients treated increased by 52.9% since 1996, especially significant for an area experiencing significant population losses.

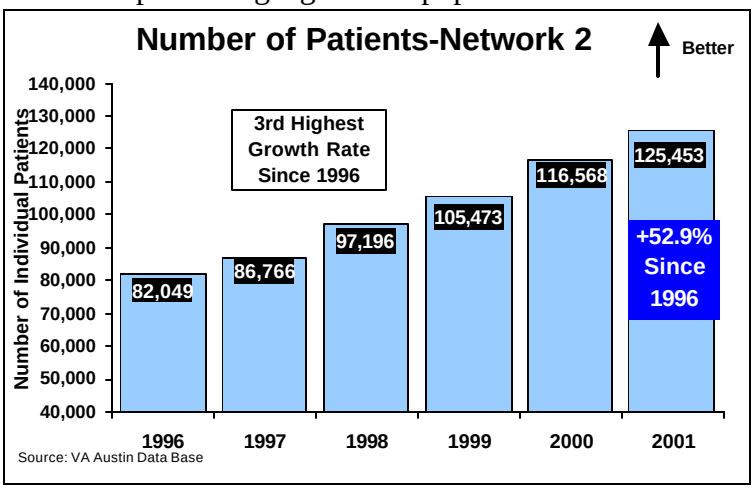


Fig. 7.2N

7.2O-Percentage of Patients Lost

Crucial to Network 2's success in expanding patients treated has been our ability to retain a large percentage of existing patients.

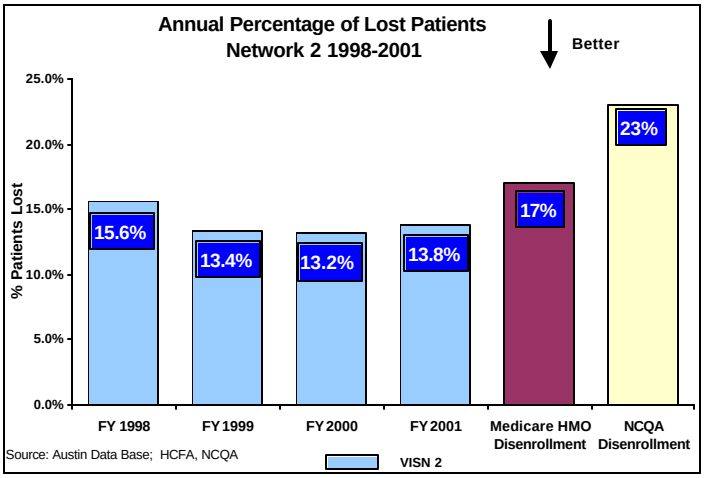


Fig. 7.2O

The reduced rate of loss of 13% in 2000 is particularly significant in an area experiencing a loss of population, in favor of sun belt states. Increasing and retaining veteran patients is crucial to success in generating greater VA funding.

7.2P-Growth in Patient Enrollment

Network 2 achieved a 34.3% growth in patients, comparing favorably with NY State's largest health care organizations.

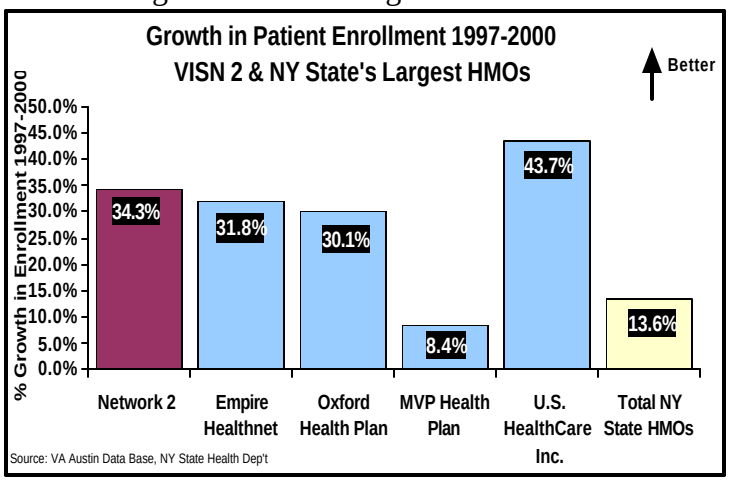


Fig. 7.2P

7.2Q-Annual Patient Growth

Patient Growth increased by 7.3% annually surpassing the annual health care growth rate of 7%.

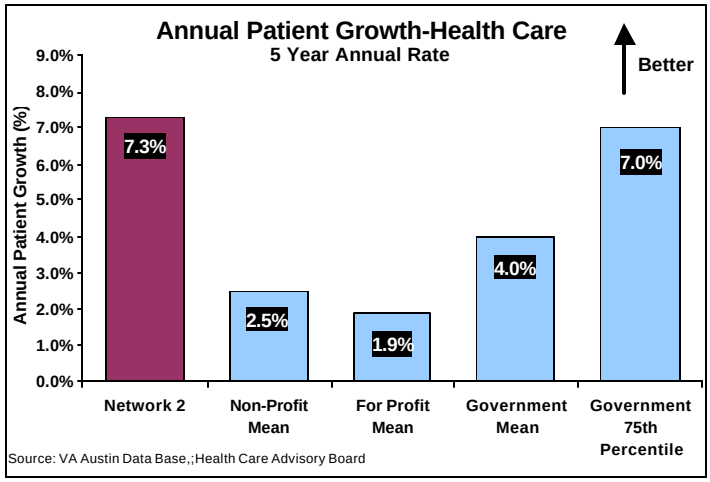


Fig. 7.2Q

7.2R-Category A Veterans by Major Market

Improvements in market penetration among the highest priority veterans increased for the four largest markets, three of which approached or surpassed VA best (VISN 8).

Category A Veteran Market Penetration by Major Market

Major Markets	1998	1999	2000	2001	2001 VA Mean	2001 VA Best
Albany	34.3%	36.3%	38.1%	**38.3%**	34.3%	44.7%
Bath	44.7%	47.7%	48.8%	**52.4%**	34.3%	44.7%
Syracuse	37.3%	39.8%	38.0%	**41.4%**	34.3%	44.7%
WNY	38.9%	40.7%	44.8%	**49.0%**	34.3%	44.7%
TOTAL	**34.8%**	**36.5%**	**37.5%**	**39.5%**	34.3%	44.7%

Fig. 7.2R Source: VA Austin Data base

7.3 WORK SYSTEM RESULTS

7.3A-Employee Satisfaction-Website surveys demonstrated over 70% satisfaction with regard to selected elements of employment. Employee Quick Cards, based upon the patient Quick Card principle,

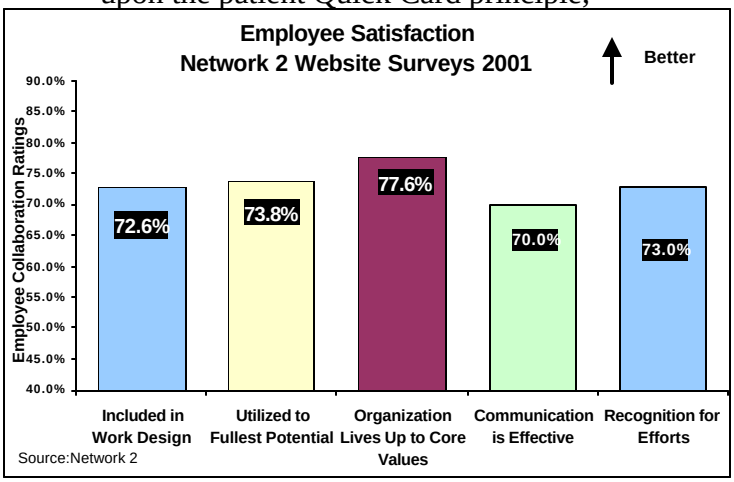


Fig. 7.3A

have been developed and will soon be distributed regularly to staff.

7.3B-Overall Employee Satisfaction-62% of staff rated overall employment good or excellent, with 9% citing very poor or poor.

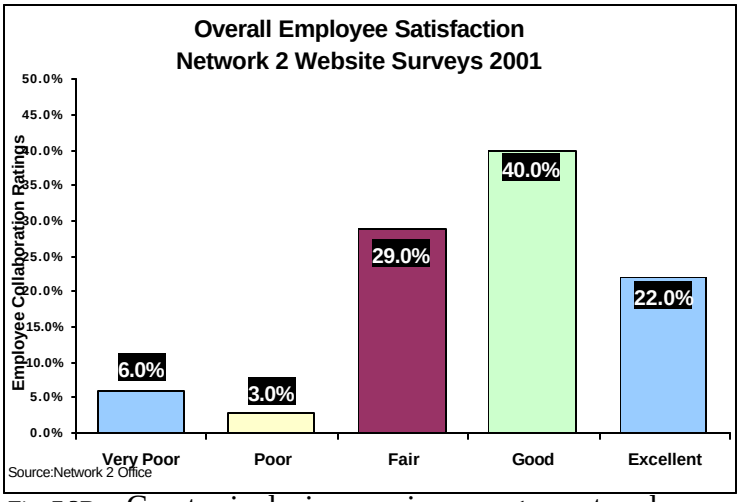


Fig. 7.3B

Greater inclusiveness in management and decision making, and concerted efforts to involve front-line staff, are central strategies to achieve more meaningful employment.

7.3C-Training Dollars Per employee

Expenditures per employee increased by 11% in 2001.

7.3D-Goal Sharing Participation

All staff have participated in the goal sharing program in FY 2001, VA 's first Network-wide program aligned to organizational goals, winning the OPM Pillar Award in 2000 and the 2001 VHA

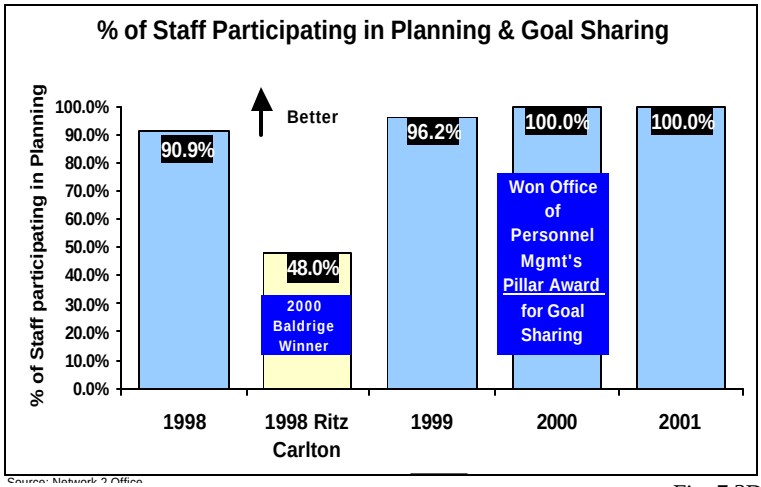


Fig. 7.3D

Undersecretary Award for Innovation.

7.3E-Goal Sharing Distributions to Staff

Distributions for goal sharing have continued to increase in proportion to achieved successes, specifically in accordance with organizational goals.

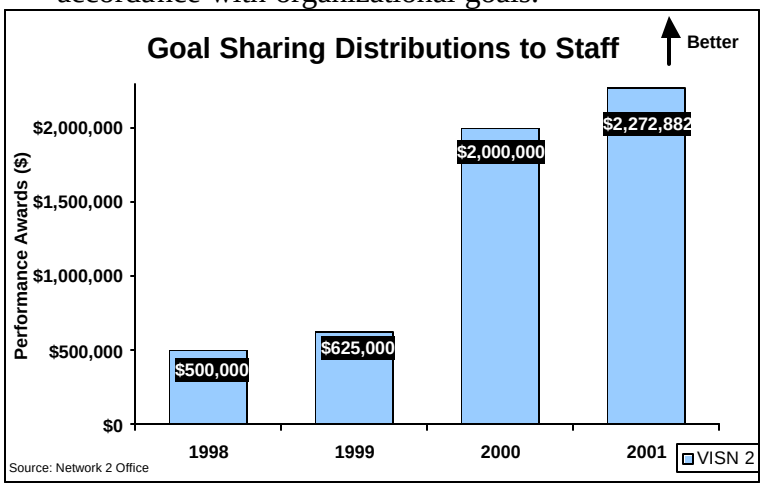


Fig. 7.3E

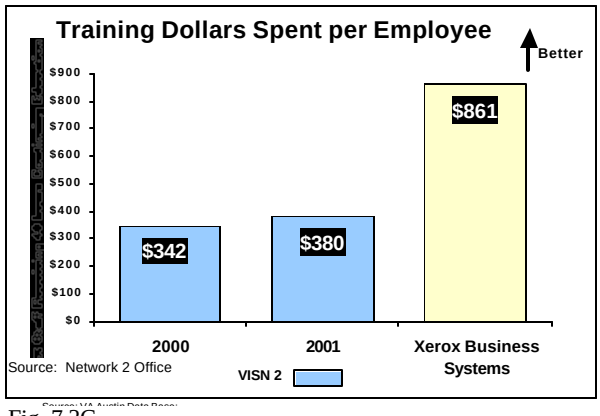


Fig. 7.3C

7.3F-Performance Awards to Staff 2001

$3.8 million was distributed in cash awards in 2001, recognizing staff for their contributions to organizational successes.

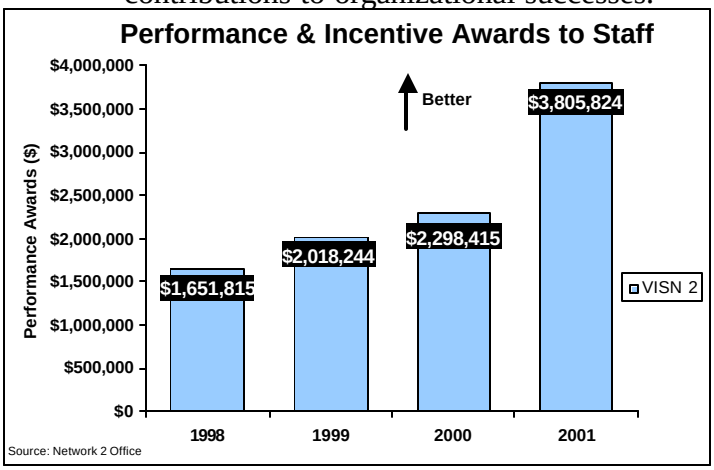


Fig. 7.3F

7.3G-Continuing Education

95% of staff received a minimum of 40 hours of continuing education, surpassing the target of 50%.

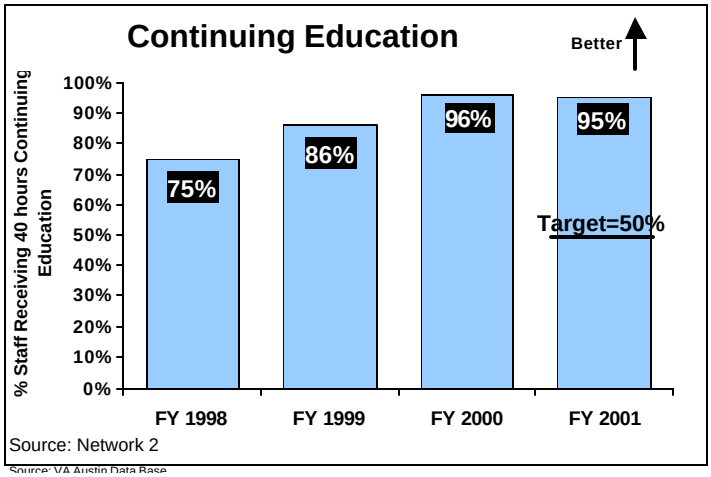


Fig. 7.3G

7.3H-Employees trained in Core Competencies-100% of staff were trained in 2001.

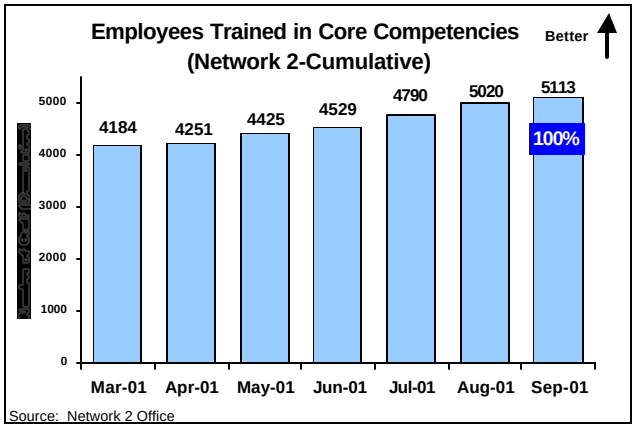


Fig. 7.3H

7.3I-Training in HPDM

Over 90% of staff have been given orientation to the High Performance Development Model (HPDM), designed to promote staff development in accordance with changing skill requirements.

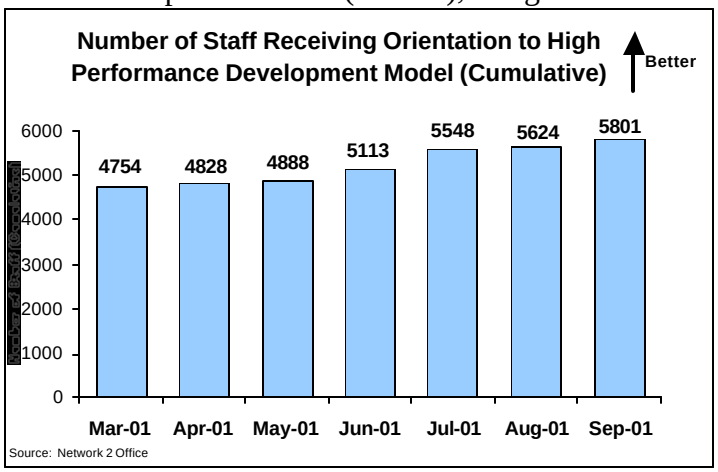


Fig. 7.3I

7.3J. Training in Computer Literacy

More than 5000 staff received training in computer literacy through September 2001 in order to acquire and maintain the skill sets for a technologically advanced workplace.

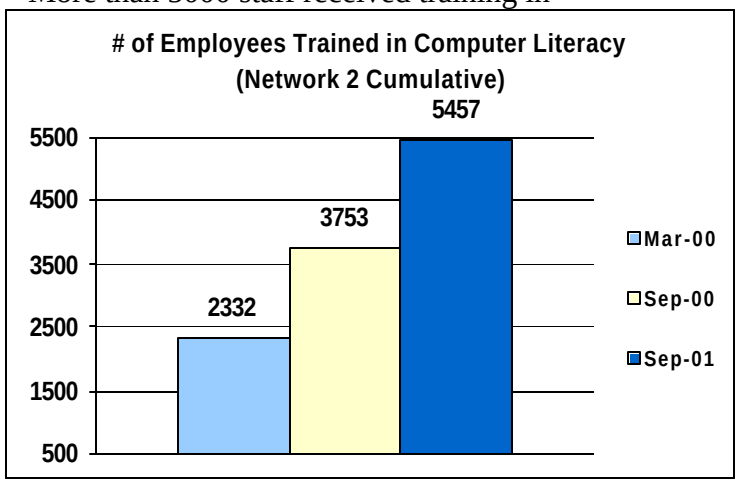


Fig. 7.3J

Network 2 has focused specifically on computer based skills in support of its significant reliance on data driven decision making, its use of advanced data systems described in Section 4, and its award winning internet site.

7.3K-Physician Turnover Rates
Physician turnover rates improved to 8.9% in 2000. Network-wide evaluations have been conducted in July 2000. Physician retention is being addressed through academic affiliations, research opportunities and professional association.

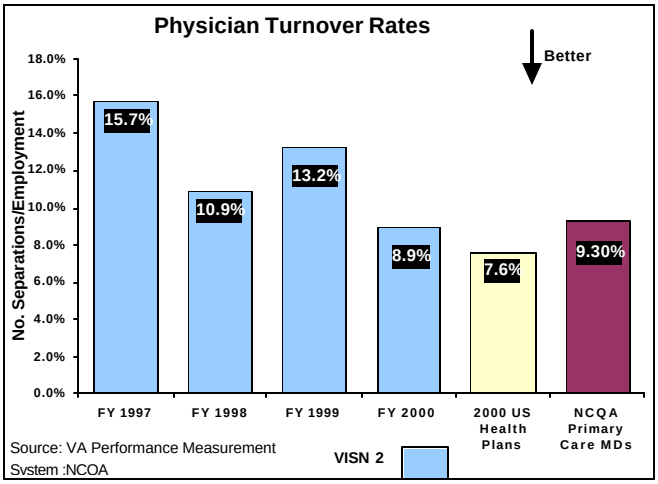


Fig. 7.3K

7.3M-Lost Time injury Claims Rate- The lost time claims rate decreased from 6.5 per 100 employees to 1.6 in 2000, a 75% reduction, the greatest improvement among 22 networks. The resulting 2000 score of 1.6 per 100 employees is approximately half the U.S. rate reported by the Bureau of Labor Statistics.

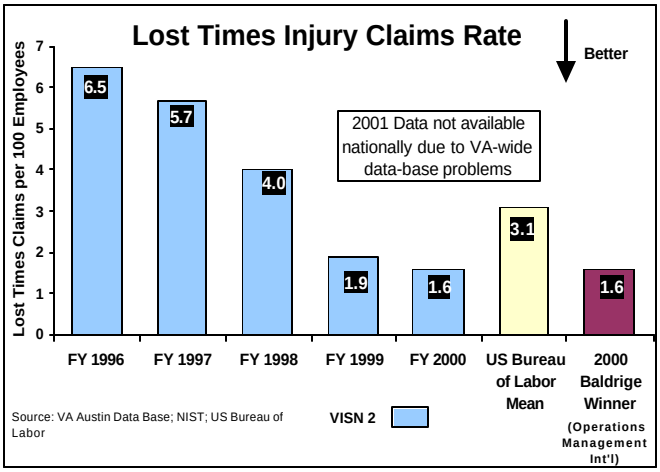


Fig. 7.3M

7.3 L-RN Turnover
Overall Nurse turnover rate equaled 7.2%, well below the U.S. turnover rate for registered nurses. A nurse recruitment and retention work group was established, producing site specific evaluations and strategies.

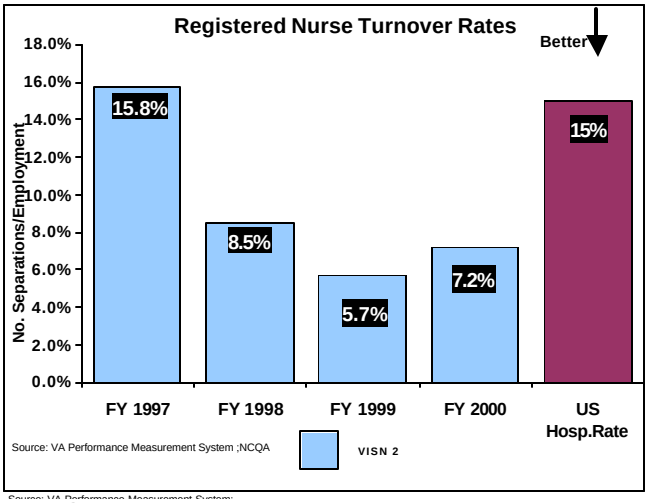


Fig. 7.3L

7.3N-Provider Training Effectiveness
A significant percentage of continuing education hours presented in 7.3G involved customer service training, with particular emphasis on improving staff-patient interactions and improving courtesy . Nurses and Physicians Nurses and physicians received mandatory training

% PROBLEMS RELATED TO STAFF COURTESY

1996	1997	1998	1999	2000	2001	Change	Description
15.0%	8.0%	5.6%	4.7%	5.3%	4.9%	67% Reduction in problems	VHA's Greatest Improvement Since 1996

Fig. 7.3N

earmarked specifically for health care providers, in order to promote a caring, emotionally-supportive environment. Significant Improvements in patient satisfaction since 1996, specifically in these key areas, are our best measure of the effectiveness of these training programs.

7.4 ORGANIZATIONAL EFFECTIVENESS RESULTS

Clinic Waiting Times

7.4A-Clinic Waiting Times (Days)

The exceptional level (30 days) was reached for 5 of 6 clinics, with notable improvements in Primary care, orthopedics and urology.

Clinic Waiting Times in Days

Network 2 Clinics	2000	2001	Exceptional Level Target	VA Best	Best Practice within Wales Health System (UK)	Comments
Primary Care	46.4	30	30	19	14	Exhaustive web-based searches confirmed that US health systems **do not** publish or disclose clinic waiting times; the United Kingdom does reveal such information.
Audiology	24.6	22	30	12	70	
Cardiology	22.6	29	30	13	21	
Orthopedics	34.1	16	30	15	14	
Urology	30.4	23	30	15	21	
Eye	24.1	52	30	20	28	

Exceptional

Fig. 7.4A

7.4B-Waiting for Clinic Appointments

Waiting times decreased significantly in each of the 5 clinics measured since 1998. Waiting time reductions in excess of 40 percent are consistent with Network 2's excellent satisfaction related to waiting times, achieving VA's best in 2001. Continued involvement with the Institute for Health Care Improvement (IHI) Collaborative will further improve clinic waiting times.

Waiting Time for Clinic Appointment (in Minutes)

Clinic	1998	1999	2000	2001	% Reduction	Network 2 had VA's Highest Satisfaction Related to Waiting Times in 2001
Cardiology	32	23	19	15	-53.1%	
Eye	32	23	21	19	-40.6%	
Orthopedics	33	22	16	19	-42.4%	
Primary Care	32	22	20	19	-40.6%	
Urology	31	21	19	16	-48.4%	

Fig. 7.4B

7.4C-Compensation & Pension Exam Turnaround (Days)

Network 2 has consistently surpassed the 35 day standard between 1999 through 2000, with a 29 day turnaround time.

A team nominated by the VISN 2 C&P Exam Workgroup has been selected to participate in the Collaborative Breakthrough Series on Improving the Compensation and Pension Examination Process.

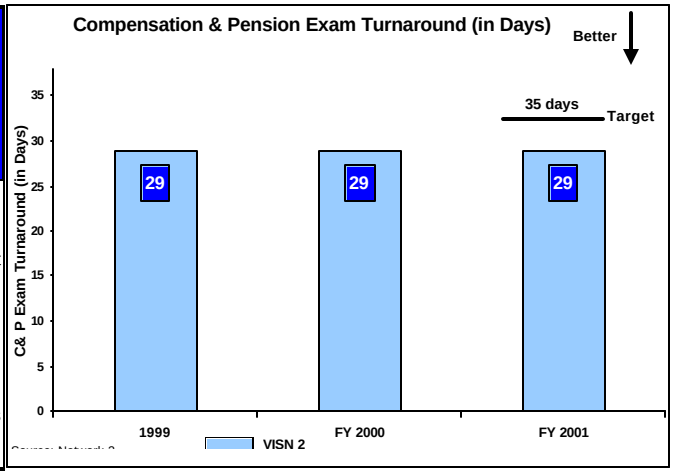


Fig. 7.4C

7.4D-Compensation & Pension Exam Sufficiency (%)

Overall sufficiency of exams has improved to over 99%, approaching VA best of 99.8%. Two of the major goals of the VISN 2 Compensation and Pension Workgroup includes training/education of VHA and VBA staff and bridging communication gaps between the two divisions.

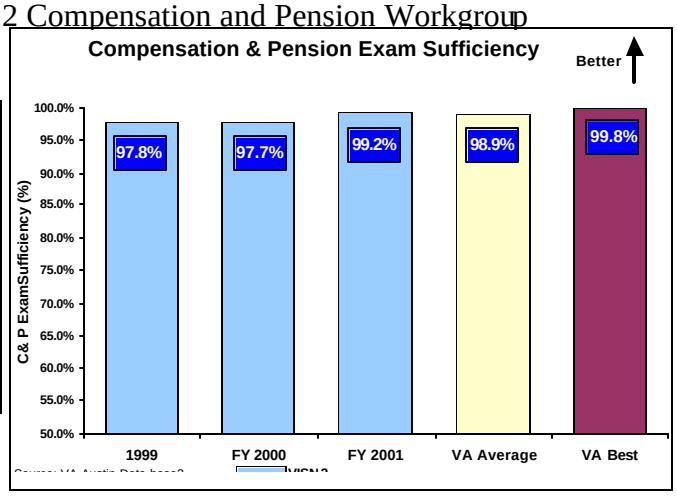


Fig. 7.4D

7.4E-Turnaround Time for Eyeglasses

Turnaround time improved to 46 hours in 2001, surpassing the national target of 48 hours.

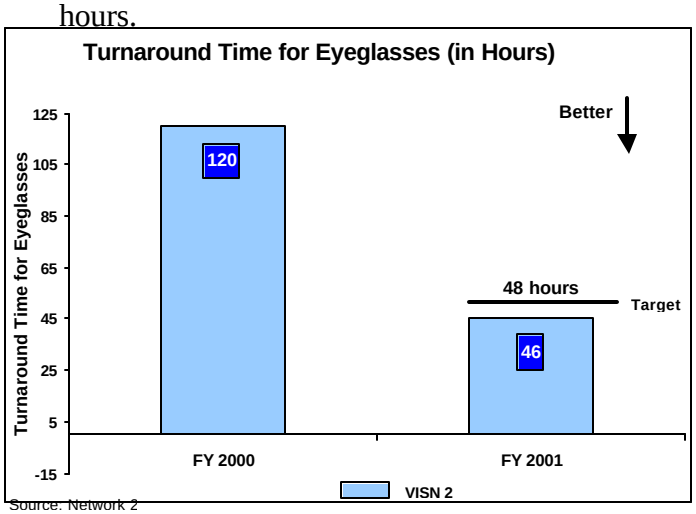


Fig. 7.4E

7.4F-Acute Bed Days per 1000 Patients

Network 2 achieved the greatest reduction in bed days per 1000 patients since 1998. The represents the degree to which we have effectively transformed our health care system, increasing patients treated by over 50% while also improving quality and patient satisfaction scores (**Figs 7.1A-Z**).

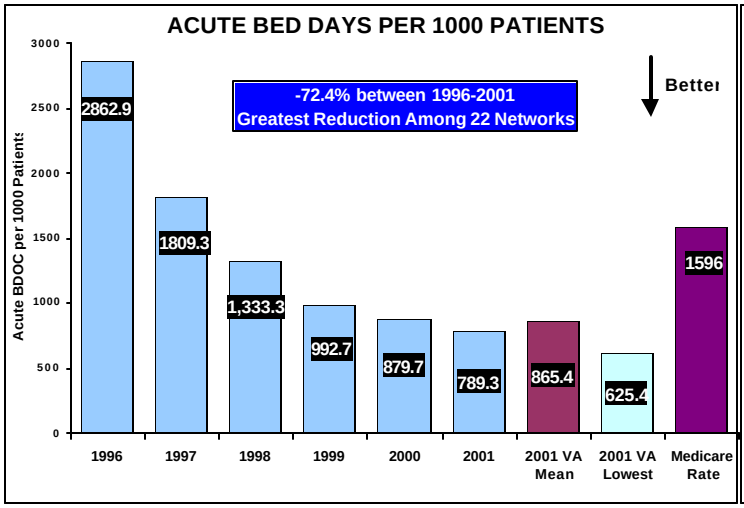


Fig. 7.4F

Supplier & Partner

7.4G-Consolidated Mail Out Program Turnaround Time (Hours)

Turnaround improved to 37 hours in 2001, surpassing the 48 hour target.

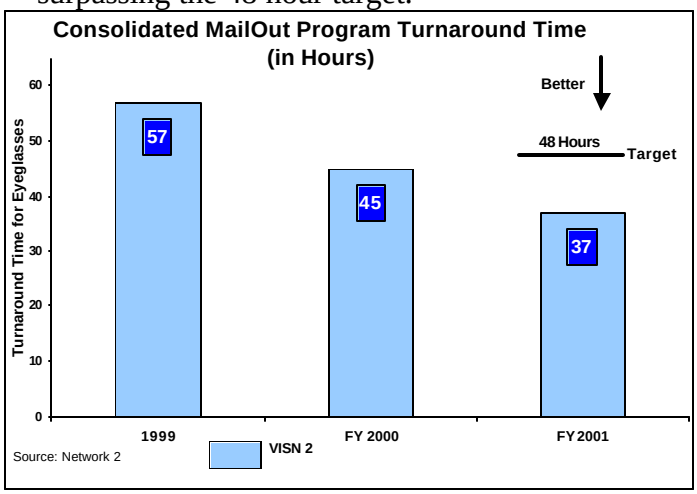


Fig. 7.4G

7.4H-Contract Standardization Savings

Through effective negotiation with vendors and suppliers as well as integration of Acquisition & Materiel Management programs throughout Upstate New York, significant cost savings have been generated.

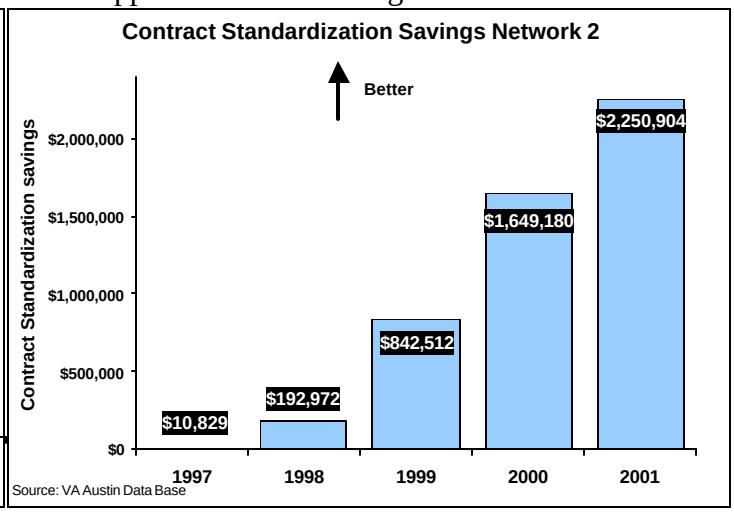


Fig. 7.4H

7.4I-Cost Avoidances-Consolidated Purchasing & Gov't Agency Cooperation

Through effective consolidated procurement efforts and cooperation with other government agencies, significant cost avoidances have been realized in 2001.

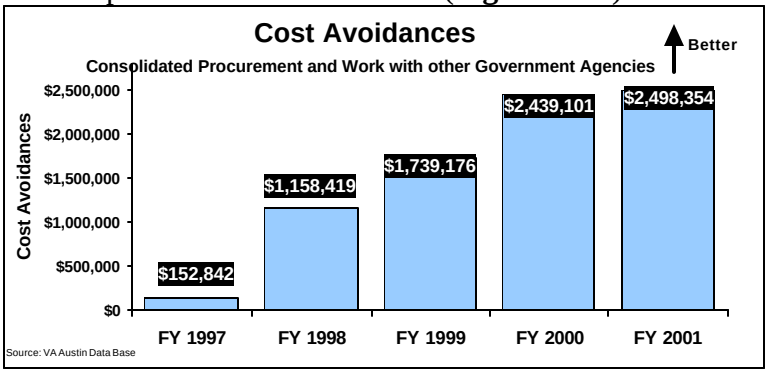


Fig. 7.4I

Accreditation & Awards

7.4 J-Joint Commission Accreditation

JCAHO Accreditation scores exceeded the national health care averages for each of the four survey programs.

JCAHO ACCREDITATION

2000 JCAHO PROGRAM	NETWORK 2 AVERAGE	NATIONAL HEALTHCARE AVERAGE
Hospital	91.2	91
Behavioral Health	95.6	94
Long Term Care	94.2	91
Home Care	94.2	92

Fig. 7.4J

7.4K-National Committee on Quality Assurance-one of two VA Networks accredited.

NCQA ACCREDITATION

Accredidation	Rating
2-YEAR Network-wide Accredidation	Rating of Commendable

Fig. 7.4K

7.44L-Committee on Accreditation of Rehabilitation Facilities (CARF

Accreditation was received at all sites and Network-wide for the Homeless program with numerous exemplary citations.

Committee on Accredidation of Rehabilitation Facilities (CARF)

Site	Accredited Program	Behavioral Health Program Standards	# of Examples of Exemplary Conformance to Standards	Employment & Community Services Program Standards	# of Examples of Exemplary Conformance to Standards
Albany	Chemical Dependency Rehab	Out-Patient Treatment	3		
	Community Day /MHICM	Case Mgmt/Out-Pt Treatment			
	Vocational Rehab			Employee Development	3
Bath	Domiciliary Care	Residential Treatment	2		
	Vocational Rehab	Employee Development			
Canandaigua	Mental Health Intensive Case	Case Management	4		
	Management (MHICM)				
	Substance Abuse Services (SAS)	Outpatient Treatment			
	Vocational Rehabilitation	Employment Planning			
Syracuse	Community Day	Partial Hospitalization	2		
	Chemical Dependency Clinic	Out-Patient Treatment			
	Vocational Rehabilitation			Employee Development	4
Western NY	Day Treatment	Partial Hospitalization			
	Veterans Integrated Substance	Out-Patient Treatment			
	Treatment Alliance (VISTA)/SAS				
	Vocational Rehabilitation			Employment Planning	
VISN 2	Homeless Program			Case Management	7

Fig. 7.4L

7.4M-Network Awards & Recognition

AWARDS & NOTABLE PRACTICES BY BALDRIGE SECTION

BALDRIGE SECTION	AWARDS AND OTHER NOTABLE PRACTICES RECOGNIZED
Leadership	● **2001 ROBERT CAREY AWARD** ***VHA Virtual Learning Center Innovations***: VA / NYS Regional Conferences
Strategic Planning	● **2000 OPM Award for Goal Sharing** ***Kizer Site Visit January 2001***: Interactive Planning
Patients Other Customers	● **1999 UNDERSECRETARY INNOVATIONS AWARD - CUSTOMER SERVICE COUNCIL** ● **2000 SCISSORS AWARD-VIRTUAL HELP DESK** ***Kizer Site Visit January 2001***: Quick Cards, Comping (Service Recovery
Information & Analysis	● **1999 BEST FEDS ON THE WEB** ● **2000 UNDERSECRETARY'S AWARD-ON-DEMAND LEARNING SYSTEM** ● **2001 VHA BEST OF THE WEB** ***Kizer Site Visit January 2001***: Decision Support Objects ***VHA Virtual Learning Center Innovations***: Awards Planning Calendars, On-Demand Technology, Data Analyst Training Program, Virtual Help Desk, Web Initiatives at 13th National Veterans Golden Age Games ***2001 Veteran Health Service Best Practices Source Book***: Customer Service Timeliness Measure Rollup Reports, Quick Cards, Web Site and Virtual Help Desk
Staff Focus Process Management Organizational Results	● **2000 OPM PILLAR AWARD** ● **2001 MANAGEMENT-LABOR PARTNERSHIP AWARD** ● **2001 VHA UNDERSECRETARY AWARD FOR HR - GOAL SHARING** ***2001 VETERAN HEALTH SERVICE BEST PRACTICES Source Book***: Great Expectations Customer Service Training, Goalsharing ***May 2000 VA Quality/Safety Conference***: **Patient Safety** ***VHA Virtual Learning Center Innovations***: Implementing a Disease Management Program, Veteran Service Centers, Standardized CBOC Operations Manual On-Line ***2001 / 2002 VHA Performance Measurement System Best Practices*** : Colorectal Screening, Mental Health follow-up, Major Depression Screening, Diabetes Foot sensory Exams, Highest Satisfaction for Access, Waiting time, Specialists and HBPC ***VHA Virtual Learning Center Innovations***: Mental Health Follow-up, Evaluation of Patients on Neuroleptics, Addition Severity Index Screening

Fig. 7.4M

GLOSSARY OF TERMS

TERM	DEFINITION
ADHC	Adult Day Health Care-A Day Care program providing an alternative to hospitalization for extended care patients
Alternate Revenue	Funding acquired outside of the federal appropriations process including collections from insurance carriers and private payers; sharing agreements
BVAHC	Behavioral VA Health Care Line
Care Lines	Organizational units through which patients are treated throughout Network 2 (Medical VA Care, Behavioral VA Health Care, Geriatrics & Extended Care, Diagnostics & Therapeutics, Mgmt Systems
Category A	Veterans below a specified income threshold (Medically Needy) or veterans with a service–connected injury
CBOC	Community Based Outpatient Clinic –operated through VA staff or through contract with provider
CDI	Chronic Disease Index The index consists of 13 clinical interventions that assess how well VHA follows nationally recognized guidelines for 5 high volume diagnoses: ischemic heart disease, hypertension, chronic obstructive pulmonary disease, (COPD) diabetes mellitus, obesity
Clinical Practice Guideline (CPG)	Set of clinical protocols to aid in patient care decisions
Comping	The comping program is an integral part of customer service, and particularly service recovery. It is the series of actions that a staff member can take to turn a negative customer service event into a *positive, memorable* one
Complex Patients	Patients who require specialty care services, often on a chronic basis
CQI	Continuous Quality Improvement
CSC	Customer Service Council
D & T	Diagnostics and Therapeutics Care Line (Pharmacy, Laboratory, Radiology, Audiology, Phys. Medicine & Rehab)
DRG	Diagnosis Related Groups-A classification of clinically similar patients based upon inpatient diagnoses
DSO	Decision Support Objects provide desktop access to key performance measure and operational data
ELC	Executive Leadership Council-the equivalent of the Governing Body within Network 2 Establishing Organizational Mission, Responsible for both Tactical and Long Range Objectives, Issues Required Action, Evaluates Organizational Performance
FTEE	Full Time Employee Equivalents-the unit of staffing measure within VHA
GEC	Geriatrics & Extended Care Line
HBPC	Home Based Primary Care-program through which staff visit extended care patients in the home, providing primary care services
HPDM	High Performance Development Model-designed to promote staff development in accordance with changing skill requirements
Internal Shopper Program	The Internal Shopper Program is a customer service initiative designed to focus on the expectations of our customers as seen through the eyes of a fellow VA employee
JCAHO	Joint Commission on Accreditation of Health Care Organizations
Local Leadership Committee LLC	Counterpart to the ELC at the local level for coordinating Network and care line requirements
MAC	Management Assistance Council is a forum for obtaining stakeholder feedback
Market Penetration	Percentage of veterans treated in a specific locality
MCCF	Medical Care Collection Fund-Alternate revenue collected from patients, insurance carriers

Mental Health Follow-Up	Patients who receive outpatient care related to mental health within 30 days following discharge.
MVAC	Medical VA Care Line (Medicine, Surgery, Primary Care)
NAO	Network Authorization Office-organizational unit established to improve patient transfers, emergency care access and treatment at non-VA facilities
NCQA	National Committee on Quality Assurance-Primary Accrediting agency for HMOs
Network	One of 22 organizational units (Veterans Integrated service Networks (VISNs) which constitute the VA Health Care System
NHCU	Nursing Home Care Unit-VA-operated skilled-nursing care unit
NRM	Non-Recurring Maintenance Projects
NSC	Non-Service Connected Patient
Prevention Index (PI)	Prevention Index -consists of 9 clinical interventions that measure how well VHA follows nationally recognized primary prevention and early detection recommendations for 8 diseases with major social consequences: influenza and pneumococcal diseases, tobacco use, alcohol abuse, cancer of the breast, cervix, colon, and prostate
Priority Groups	Classification of Veterans categorized for enrollment purposes from 1 through 7, based upon degree of service connection, income and other factors
PTSD	Post Traumatic Stress Disorder
Pulse Points	Monthly report of performance measures
Quick Card	Customer survey program that provides immediate feedback
SC	Service Connected Patient
SCI	Spinal Cord Injury
Six for 2006	6 VHA strategic goals to be reached by 2006
SMI	Seriously Mentally Ill
Special Disability Programs	Programs provided for 6 special populations of disabled veterans : Amputation, Blindness, PTSD, Serious Mental Illness, Spinal Cord & Traumatic Brain Injury
Special Emphasis programs	Programs that uniquely characterize VA health care including Addictive Disorders, Homeless, Prosthetics, Gulf War, Former POW, Ionizing Radiation, etc.
Telemedicine	Advanced technology applying high-powered video cameras to assist in patient diagnosis and treatment from remote locations
TSPQ	Transforming Systems Performance & Quality Council (TSPQ)Responsible for Network Operations Coordinates VISN-Wide Actions & Priorities Operationalizes Network Strategic Goals
Unique Patients	The number of individual (unduplicated) patients treated
VERA	Veterans Equitable Resource Allocation Model-methodology through which VHA appropriations are distributed among 22 networks
VHA / VA	Veterans Health Administration / Veterans Affairs
Virtual Help Desk	Computerized medium through which VA customers may request on-line information through the Network 2 Web Page.
VISN	Veterans Integrated Service Network -One of 22 organizational units which constitute the VA Health Care System
VSC	Veterans Service Centers are designed to provide "one-stop shopping" for veterans, by providing a central point at each Medical Center for helping veterans and guests with questions about accessing VA Healthcare, VA Healthcare benefits, and eligibility
VSO	Veterans Service Organization